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UNITED STATES
DEPARTMENT
OF LABOR

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CHILDREN'S
BUREAU

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Chief

Grants to States for
Maternal and Child Welfare
Under the Social Security Act

Approved August 14, 1935

Title V, Parts 1, 2, 3

Maternal and Child-Health Services
Services for Crippled Children
Child-Welfare Services

Maternal and
Child Welfare
Bulletin No. 1

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Grants to States for Maternal and Child Welfare Under the Social Security Act, Approved August 14, 1935

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PROVISIONS OF THE SOCIAL SECURITY ACT[1]

The purpose of the Social Security Act adopted by Congress and approved by the President August 14, 1935, is stated in the general title of the Act to be the following:

> *To provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment-compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.*

The Act has 11 titles, as follows:

I. Grants to States for old-age assistance.
II. Federal old-age benefits.
III. Grants to States for unemployment-compensation administration.
IV. Grants to States for aid to dependent children.
V. Grants to States for maternal and child welfare.
VI. Public-health work.
VII. Social Security Board.
VIII. Taxes with respect to employment.
IX. Tax on employers of eight or more.
X. Grants to States for aid to the blind.
XI. General provisions.

The Act provides in title XI that if any of its provisions is held invalid the remainder of the Act shall not be affected thereby.

The Social Security Board is given responsibility for the Federal administration of all the grants-in-aid features of the Act except the following:

Title V: Part 1, Maternal and child-health services; part 2, Services for crippled children; part 3, Child-welfare services—all to be administered by the Children's Bureau, United States Department of Labor.

Title V: Part 4, Vocational rehabilitation—to be administered by the Federal agency dealing with vocational rehabilitation [the Office of Education, United States Department of the Interior].

Title VI: Public-health work—to be administered by the Public Health Service, United States Department of the Treasury.

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[1] Public—No. 271—74th Congress [H. R. 7260].

In addition to the indirect benefits to children provided by the other titles of the Social Security Act, titles IV and V specifically provide grants-in-aid to the States for promoting the health and welfare of children. The provisions of title IV, which are to be administered by the Social Security Board, may be summarized briefly as follows:

For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy dependent children, an appropriation of $24,750,000 is authorized for the fiscal year ending June 30, 1936, and such sums as may be necessary thereafter, to be used for making payments to States which have State plans for aid to dependent children approved by the Social Security Board.

The term "dependent child" is defined to mean a child under the age of 16 years who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living in the home of his father, mother, or other relative or relatives, as specified in the Act.

State plans must provide for: State-wide operation, the plan to be in effect in all political subdivisions of the State and if administered by them to be mandatory on them; financial participation by the State; administration, or supervision of administration, by a single State agency; granting to any individual whose claim with respect to aid to a dependent child is denied, opportunity for a fair hearing before the State agency; such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel), as are found by the Social Security Board to be necessary for the efficient operation of the plan; and such reports by the State agency as may be required by the Board.

No residence requirement is to be imposed which would result in the denial of aid to an otherwise eligible child (1) who has lived in the State for 1 year immediately preceding the application for aid or (2) who was born in the State within 1 year immediately preceding the application if his mother had lived in the State for a year immediately preceding his birth.

States with approved plans will be reimbursed to the extent of one-third of the total expenditures, except that the State or local administrative unit will bear the full cost of any payment in excess of $18 per month for any dependent child, or, if there is more than one dependent child in the same home, in excess of $18 for one such child and $12 for each other child.

PROVISIONS OF TITLE V, GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE[2]

The provisions of title V, which, except for part 4 (sec. 531) are to be administered by the Children's Bureau under the supervision of the Secretary of Labor, are summarized in the chart facing page 14.

The annual appropriations authorized in the Act are as follows:

Maternal and child-health services	$3, 800, 000
Services for crippled children	2, 850, 000
Child-welfare services	1, 500, 000
Total	8, 150, 000

An annual appropriation of $425,000 is authorized to enable the Children's Bureau to carry on necessary administrative functions and to make such studies and investigations as may be necessary to promote the efficient administration of the parts of the Act for which it is responsible.

All allotments to States are to be made by the Secretary of Labor, who is to include in his annual report to Congress a full account of the sections of the Act that are administered by his Department. With respect to maternal and child-health services and services for crippled children, the Secretary of Labor is also to prescribe reports and information to be furnished by the cooperating State agencies, to require such investigations as may be necessary in connection with estimates submitted by the State agencies, and to withhold payments after reasonable notice to the State agency and opportunity for hearing, if it is found that the State agency has failed to comply substantially with any provision that is required by the Act to be included in the State plan. All certifications of amounts to be paid to States by the Secretary of the Treasury are to be made by the Secretary of Labor.

Examination of the provisions of title V which are concerned with maternal and child health, crippled children, and child welfare shows that the primary purpose of these portions of the Act is to extend and strengthen services for mothers and children in rural areas, in areas suffering from severe economic distress, and among groups in special need. These are the people who have been hitherto, for the most part, outside the reach of health and welfare services that have been more generally available in the larger cities. In this connection it is significant to note that since 1929 rural infant mortality rates have been higher than urban rates—a reversal of the conditions existing in prior years, when urban rates exceeded those in rural areas. From 1933 to 1934 the rural infant mortality rate in the United States increased from 59 to 62 per 1,000 live births, and the urban rate increased from 57 to 58.[3] Certain urban districts, however, still have exceedingly high infant mortality rates, and programs to be developed by the States under the Act will reach some of these areas as well as the less populous portions of the country.

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[2] Except for sec. 531, which deals with vocational rehabilitation. For text of pertinent sections of the Act, see p. 15. The Act simply authorizes appropriations. Actual appropriations will be made annually by Congress.

The State agencies having administrative or supervisory responsibility under the sections of the Act under consideration are the following:

Maternal and child-health services	State health agency.
Services for crippled children	The State agency having responsibility for medical care for crippled children. [If several agencies are responsible, one should be designated by agreement of those concerned.]
Child-welfare services	State public-welfare agency.

As to maternal and child-health services and services for crippled children, the Act requires that the plans submitted by the States shall include provision for cooperation of medical, nursing, health, and welfare groups and organizations, and, in the case of services for crippled children, whatever State agency is charged with responsibility for administering State laws for vocational rehabilitation of physically handicapped children. Plans for child-welfare services are to be developed jointly by the State agency of public welfare and the Children's Bureau; and, though their content is not prescribed by the Act, they will certainly be developed with a view to the establishment of cooperation with all groups concerned with the welfare of children, so as to avoid duplication and give maximum service.

Emphasis on the strengthening of local services is included in all three portions of title V relating to child health and child welfare. Plans submitted for maternal and child-health services must show that their operation will assist in the extension and improvement of local maternal and child-health services, and the sections of the Act relating to crippled children will involve the development of such State and local services as may be required by the conditions in the different States. The appropriation for child-welfare services is available for payment of part of the costs of local services and for developing State services for the encouragement and assistance of community child-welfare organization, chiefly in areas predominantly rural.

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[3] Provisional figures issued by the Bureau of the Census.

Public funds expended by local political subdivisions may be counted in the funds required by the several portions of title V (other than vocational rehabilitation) to be made available within the State. Private funds can be used for matching purposes only if they are paid into the public treasury and become fully available for public expenditure.

All allotments to States (except such allotments for maternal and child-health services as are made on the basis of special need) are available until the end of the second fiscal year succeeding that for which the allotment was made—in other words, for 3 consecutive fiscal years. Payments from the allotment for any fiscal year cannot be made, however, until available funds for prior years have been exhausted.

All payments to States will be made by the Secretary of the Treasury, through the Division of Disbursement of the Treasury Department, on certificate by the Secretary of Labor and prior to audit or settlement by the General Accounting Office.

MATERNAL AND CHILD-HEALTH SERVICES

Purpose of Federal grants

The annual appropriation authorized, $3,800,000, is for the purpose of enabling each State to extend and improve, as far as is practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.

Federal administration

The administration of this part of the Act will be under the immediate direction of a Maternal and Child Health Division of the Children's Bureau of the United States Department of Labor, headed by a physician and receiving general supervision from the Assistant Chief of the Children's Bureau, who is also a physician.

Amounts available to States

The apportionment of funds under the terms of the Act is shown in table 1. The amount of $3,800,000 authorized for maternal and child health is divided as follows:

Fund A (see sec. *502*(*a*))

Available for payment of half of total expenditure under approved plans (within the amount available for allotment to each State)		$2,820,000
Uniform apportionment, $20,000 to each State	$1, 020, 000	
Apportionment on basis of live births	1, 800, 000	

Fund B (see sec. *502*(*b*))

Available for allotment according to financial need for assistance in carrying out State plan, after number of live births is taken into consideration	980,000

State funds appropriated or otherwise provided by the State itself must be made available for payment of part of the costs of approved plans. Funds appropriated or made available by political subdivisions (counties, cities, or towns) may also be counted as part of the total funds made available for maternal and child-health activities, provided such local activities are brought into the State plan and under the general supervision of the State department of health. So also may any allotment made from the Federal fund of $980,000 be counted in the total amount made available for this purpose. If application is made for grants from this fund of $980,000, evidence of need for assistance in carrying out the State plan must be submitted with the plan. State or local funds used for matching any other Federal appropriation cannot be counted in establishing eligibility for Federal assistance under this portion of the Social Security Act.

TABLE 1.—*Apportionment of funds to be available annually for grants to States for maternal and child-health services under the Social Security Act, title V, part 1* (secs. 501–502)

State or Territory	Percent distribution of live births, 1934	Allotment available for payment of half the total expenditures under approved plans (fund A)			Allotment available according to financial need for assistance in carrying out State plan, after number of live births is taken into consideration (fund B) [1]
		Total	Uniform apportionment	Apportionment on basis of ratio of live births in State to total live births	
Total	100.000	$2,820,000.00	$1,020,000	$1,800,000.00	$980,000.00
Alabama	2.915	72,470.16	20,000	52,470.16	------
Alaska	.059	21,057.75	20,000	1,057.75	------
Arizona	.390	27,017.52	20,000	7,017.52	------
Arkansas	1.722	51,001.15	20,000	31,001.15	------
California	3.597	84,742.54	20,000	64,742.54	------
Colorado	.819	34,749.83	20,000	14,749.83	------
Connecticut	1.020	38,357.75	20,000	18,357.75	------
Delaware	.183	23,295.55	20,000	3,295.55	------
District of Columbia	.465	28,376.88	20,000	8,376.88	------
Florida	1.227	42,077.22	20,000	22,077.22	------
Georgia	2.969	73,433.72	20,000	53,433.72	------
Hawaii	.427	27,681.09	20,000	7,681.09	------
Idaho	.430	27,745.54	20,000	7,745.54	------
Illinois	5.060	111,087.13	20,000	91,087.13	------
Indiana	2.403	63,259.49	20,000	43,259.49	------
Iowa	1.949	55,090.03	20,000	35,090.03	------
Kansas	1.490	46,826.35	20,000	26,826.35	------
Kentucky	2.750	69,502.68	20,000	49,502.68	------
Louisiana	1.974	55,536.27	20,000	35,536.27	------
Maine	.724	33,023.54	20,000	13,023.54	------
Maryland	1.255	42,592.88	20,000	22,592.88	------
Massachusetts	2.930	72,745.35	20,000	52,745.35	------
Michigan	3.853	89,352.85	20,000	69,352.85	------
Minnesota	2.108	57,947.60	20,000	37,947.60	------
Mississippi	2.197	59,552.41	20,000	39,552.41	------
Missouri	2.717	68,908.52	20,000	48,908.52	------
Montana	.457	28,221.52	20,000	8,221.52	------
Nebraska	1.152	40,729.41	20,000	20,729.41	------
Nevada	.066	21,185.01	20,000	1,185.01	------
New Hampshire	.361	26,502.68	20,000	6,502.68	------
New Jersey	2.504	65,070.88	20,000	45,070.88	------
New Mexico	.586	30,551.87	20,000	10,551.87	------
New York	8.521	173,386.10	20,000	153,386.10	------
North Carolina	3.659	85,864.75	20,000	65,864.75	------
North Dakota	.668	32,022.81	20,000	12,022.81	------
Ohio	4.596	102,719.34	20,000	82,719.34	------
Oklahoma	2.172	59.088.82	20,000	39,088.82	------
Oregon	.600	30,806.41	20,000	10,806.41	------
Pennsylvania	7.356	152,415.40	20,000	132,415.40	------
Rhode Island	.475	28,552.07	20,000	8,552.07	------
South Carolina	2.032	56,579.13	20,000	36,579.13	------
South Dakota	.605	30,885.73	20,000	10,885.73	------
Tennessee	2.405	63,295.85	20,000	43,295.85	------
Texas	5.353	116,356.86	20,000	96,356.86	------
Utah	.580	30,441.98	20,000	10,441.98	------
Vermont	.303	25,448.24	20,000	5,448.24	------
Virginia	2.404	63,280.96	20,000	43,280.96	------
Washington	1.035	38,626.31	20,000	18,626.31	------
West Virginia	1.904	54,272.74	20,000	34,272.74	------
Wisconsin	2.361	62,490.96	20,000	42,490.96	------
Wyoming	.210	23,772.37	20,000	3,772.37	------

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[1] This column cannot be completed until State plans have been submitted.

Requirements for State plans

State plans must be approved by the Chief of the Children's Bureau if they conform with the conditions specified in section 503 (*a*) of the Act. These conditions are as follows:

1. Financial participation by the State.
2. Administration of the plan or supervision of administration of the plan by the State health agency.
3. Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan.
4. Provision for such reports by the State health agency, in such form and containing such information, as the Secretary of Labor may from time to time require and for compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports.
5. Provision for extension and improvement of local maternal and child-health services.
6. Provision for cooperation with medical, nursing, and welfare groups and organizations.
7. Provision for development of demonstration services in needy areas and among groups in special need.

Forms will be supplied to each State for use in submitting plans and budgets and reporting activities and expenditures. A plan for the entire year must be submitted at the beginning of the fiscal year (July 1), and budgets must be submitted quarterly, together with any modifications desired in the approved plan. The plans and budgets must cover the entire program, showing the part to be financed by State and local funds and the funds appropriated or otherwise made available for such purpose.

Method of payment

Payments from the fund available for payment of half the expenditures under approved plans (fund A) are to be made for each quarter, in accordance with the following procedure:

1. An estimate of the amount to be paid to the State, made by the Secretary of Labor prior to the beginning of each quarter, to be based on (*a*) an estimate made by the State and (*b*) such investigation as the Secretary of Labor may find necessary. The State estimate is to contain also a statement of the amount appropriated or made available by the State and its political subdivisions; if such funds are less than half the estimated total expenditures, the source or sources from which the difference is to be derived should be given.

2. Certification of the amount so estimated, reduced or increased to correct any differences between estimated and actual expenditures for prior quarters, by the Secretary of Labor to the Secretary of the Treasury.
3. Payment to the State, at the time or times fixed by the Secretary of Labor, by the Secretary of the Treasury through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office.

Payments from the fund available on the basis of financial need for assistance in carrying out approved plans (fund B) are to be made in a similar manner at the time or times specified by the Secretary of Labor.

Provisions regarding withholding of payments under approved plans

The Secretary of Labor shall withhold payments under an approved plan after reasonable notice and opportunity for hearing to the State agency administering the plan or supervising its administration, if he finds that in the administration of the plan there is failure to comply substantially with any provision required by the Act to be included in the plan. In such case he shall notify the State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply.

SERVICES FOR CRIPPLED CHILDREN

Purpose of Federal grants

The annual appropriation authorized, $2,850,000, is for the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as is practicable under the conditions in such State, services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions that lead to crippling.

Federal administration

The administration of this part of the Act will be under the immediate direction of a Crippled Children's Division of the Children's Bureau of the United States Department of Labor, headed by a physician and receiving general supervision from the Assistant Chief of the Children's Bureau, who is also a physician. The work of this division will be developed in close cooperation with the Maternal and Child Health Division and the Child-Welfare Division.

Amounts available to States

The general plan of apportionment is shown in table 2, which cannot be completed until State plans showing the number of crippled children in need of the services authorized and the cost of furnishing services to them have been received. A uniform initial grant of $20,000 to each State is provided. Federal funds may be granted (within the amount available for allotment to each State) only for payment of half the total expenditures under approved State plans.

The same conditions regarding State and local funds will be required as have been outlined under Maternal and child-health services (p. 5), except that there is no supplementary Federal fund available over and above the funds to be used for payment of half the total expenditures.

TABLE 2.—*Apportionment of funds to be available annually for grants to States for services for crippled children under the Social Security Act, title V, part 2* (*secs. 511–512*)

State or Territory	Allotment available for payment of half the total expenditures under approved plans		
	Total	Uniform apportionment	Apportionment on basis of need after number of crippled children in need of services and cost of furnishing services are taken into consideration
Total	$2,850,000	$1,020,000	$1,830,000
Individual State or Territory	(1)	20,000	(1)

[1] This table cannot be completed for State allotments until State plans have been submitted, giving the information on which the apportionment on the basis of need can be made.

Requirements for State plans

State plans must be approved by the Chief of the Children's Bureau if they conform with the conditions specified in section 513 (*a*) of the act. These conditions are as follows:

1. Financial participation by the State.
2. Administration of the plan or supervision of administration of the plan by a State agency (to be selected as outlined on p. 4).
3. Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan.
4. Provision for such reports by the State agency, in such form and containing such information as the Secretary of Labor may from time to time require, and for compliance with such provisions

as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports.

5. Provision for carrying out the purposes specified in this portion of the Act (see p. 9).
6. Provision for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in the State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

Forms will be supplied to each State, of the same character as those described under Maternal and child-health services (p. 8).

Method of payment

Payments are to be made on the basis of half the expenditures, under the same conditions as have been described in the section on Maternal and child-health services (p. 8).

Provisions regarding withholding of payments under approved plans

Provisions for withholding of payments are the same as those outlined under Maternal and child-health services (p. 9).

CHILD-WELFARE SERVICES

Purpose of Federal grants

The annual appropriation authorized, $1,500,000, is for the purpose of enabling the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, welfare services for the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent.

Federal administration

The administration of this section will be under the immediate direction of a Child-Welfare Division of the Children's Bureau of the United States Department of Labor, headed by a social worker and receiving general supervision from the Chief of the Children's Bureau.

Amounts available to States and conditions under which grants may be made

The apportionment of funds under the terms of the Act is shown in table 3.

The amounts are available for use by cooperating public-welfare agencies on the basis of plans developed jointly by the State agency and the Children's Bureau. They are to be used for payment of part of the cost of district, county, or other local child-welfare services in areas predominantly rural and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need. Forms will be supplied to each State for use in submitting plans and budgets and reporting activities and expenditures.

TABLE 3.—*Apportionment of funds to be available annually for cooperation with State public-welfare agencies in developing child-welfare services in areas predominantly rural and in encouraging and assisting adequate methods of community child-welfare organization in such areas and other areas of special need, under the Social Security Act, part 3 (sec. 521)*

State or Territory	Percent distribution of rural population, 1930[1]	Allotment on basis of plans developed jointly by State public-welfare agency and the Children's Bureau, for payment of part of costs of district, county, or other local child-welfare services and for developing State services as defined in the Act		
		Total	Uniform apportionment	Apportionment on basis of ratio of rural population of State to total rural population
Total	100.000	$1,500,000.00	$510,000	$990,000.00
Alabama	3.519	44,842.41	10,000	34,842.41
Alaska	.095	10,942.31	10,000	942.31
Arizona	.529	15,234.07	10,000	5,234.07
Arkansas	2.723	36,958.41	10,000	26,958.41
California	2.806	37,783.70	10,000	27,783.70
Colorado	.955	19,450.97	10,000	9,450.97
Connecticut	.879	18,703.99	10,000	8,703.99
Delaware	.213	12,110.98	10,000	2,110.98
District of Columbia		10,000.00	10,000	
Florida	1.311	22,977.83	10,000	12,977.83
Georgia	3.725	46,876.53	10,000	36,876.53
Hawaii	.315	13,121.55	10,000	3,121.55
Idaho	.584	15,780.13	10,000	5,780.13
Illinois	3.691	46,545.20	10,000	36,545.20
Indiana	2.669	36,427.29	10,000	26,427.29
Iowa	2.760	37,325.57	10,000	27,325.57
Kansas	2.130	31,088.27	10,000	21,088.27
Kentucky	3.360	43,259.42	10,000	33,259.42
Louisiana	2.346	33,229.69	10,000	23,229.69
Maine	.881	18,718.36	10,000	8,718.36
Maryland	1.215	22,029.34	10,000	12,029.34
Massachusetts	.774	17,660.81	10,000	7,660.81
Michigan	2.850	38,215.94	10,000	28,215.94
Minnesota	2.417	33,930.87	10,000	23,930.87
Mississippi	3.092	40,610.62	10,000	30,610.62
Missouri	3.276	42,429.29	10,000	32,429.29
Montana	.660	16,532.03	10,000	6,532.03
Nebraska	1.650	26,337.97	10,000	16,337.97
Nevada	.105	11,036.75	10,000	1,036.75
New Hampshire	.356	13,521.18	10,000	3,521.18
New Jersey	1.299	22,861.63	10,000	12,861.63
New Mexico	.586	15,798.00	10,000	5,798.00
New York	3.823	47,849.27	10,000	37,849.27
North Carolina	4.368	53,240.85	10,000	43,240.85
North Dakota	1.050	20,396.78	10,000	10,396.78
Ohio	3.959	49,190.45	10,000	39,190.45
Oklahoma	2.913	38,840.79	10,000	28,840.79
Oregon	.859	18,500.77	10,000	8,500.77
Pennsylvania	5.732	66,749.51	10,000	56,749.51
Rhode Island	.096	10,953.84	10,000	953.84
South Carolina	2.531	35,054.71	10,000	25,054.71
South Dakota	1.040	20,294.25	10,000	10,294.25
Tennessee	3.183	41,509.13	10,000	31,509.13
Texas	6.357	72,932.71	10,000	62,932.71
Utah	.447	14,425.58	10,000	4,425.58
Vermont	.446	14,412.05	10,000	4,412.05
Virginia	3.028	39,975.74	10,000	29,975.74
Washington	1.256	22,436.02	10,000	12,436.02
West Virginia	2.290	32,673.52	10,000	22,673.52
Wisconsin	2.563	35,374.89	10,000	25,374.89
Wyoming	.288	12,848.03	10,000	2,848.03

[1] Based on the most recent census figures.

Method of payment

Payments to the States are to be made on certification, from time to time, by the Secretary of Labor to the Secretary of the Treasury. In accordance with such certifications and at the time or times specified by the Secretary of Labor, the Secretary of the Treasury is to make payments to the States through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office.

TABULAR SUMMARY OF PROVISIONS FOR GRANTS TO STATES[1] FOR MATERNAL AND CHILD WELFARE AUTHORIZED BY THE SOCIAL SECURITY ACT APPROVED AUGUST 14, 1935

TITLE V, PARTS 1, 2, 3, AND 5. TITLE XI, SECTION 1101 (d)

Purpose	(1) Annual Federal appropriation authorized for allotment to States (2) Official who makes allotment (3) Period during which allotments are available	Method of apportionment to each State	Method and time of payment	Method of establishing eligibility for payment of funds allotted	State administrative or supervising agency	Conditions which must be met by State plan	Provisions regarding withholding of payments under approved plans	Federal administration (part 5, sec. 541, title XI, sec. 1101 (d)) of all maternal and child-welfare provisions (title V, pts. 1–3)
MATERNAL AND CHILD HEALTH SERVICES (SECS. 501-505; TITLE V, PT. 1)								
Extension and improvement of services for promoting health of mothers and children (especially in rural areas and areas suffering from severe economic distress).	(1) $3,800,000 annually. (2) Secretary of Labor. (3) Allotments for any fiscal year are available until end of second succeeding fiscal year.	A. Funds available for half total cost of services planned: (1) $1,020,000, allotted $20,000 to each State. (2) $1,800,000 allotted on basis of ratio of live births in State to total live births in United States in latest calendar year for which statistics are available. B. Funds allotted on basis of financial need of each State for assistance in carrying out plan, after number of live births has been taken into consideration—$980,000.	A. *Funds available for half total cost*, paid by Secretary of Treasury, on certification of Secretary of Labor, at time or times fixed by Secretary of Labor, on basis of estimated expenditures for quarter, reduced or increased to correct overpayments or underpayments for prior quarters. (Estimate based on *report filed by State*, containing estimate of total sum to be expended and amount appropriated or made available by State and its political subdivisions for expenditure in such quarter, and, if less than half total sum of estimated expenditures, source or sources from which difference is expected to be derived; *and such investigation as Secretary of Labor may find necessary*.) B. *Additional allotments*, on basis of need of State for assistance in carrying out plan, by Secretary of Treasury, at times designated by Secretary of Labor.	Submission of State plan for services, conforming to conditions specified, and approval of plan by Chief of Children's Bureau, who notifies Secretary of Labor and State agency of his approval.	State health agency.	(1) Financial participation by State. (2) Administration or supervision of administration by State health agency. (3) Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for efficient operation of plan. (4) Provision for such reports by State health agency as Secretary of Labor may require. (5) Extension and improvement of local maternal and child-health services administered by local child-health units. (6) Cooperation with medical, nursing, and welfare groups and organizations. (7) Provision for development of demonstration services in needy areas and among groups in special need.	By Secretary of Labor, after reasonable notice and opportunity for hearing to State agency, on finding of failure in administration to comply substantially with any provision required by the act to be included in plan. No further payments to be made until Secretary of Labor is satisfied that there is no longer failure to comply.	Annual authorized appropriation of $425,000 to Children's Bureau for all necessary expenses. Children's Bureau to make such studies and investigations as will promote efficient administration. Secretary of Labor to include full account of administration in annual report to Congress. Nothing in the Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of the Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.
SERVICES FOR CRIPPLED CHILDREN (SECS. 511-515; TITLE V, PT. 2)								
Extension and improvement (especially in rural areas and areas suffering from severe economic distress) of services for locating crippled children and for providing medical, surgical, corrective, and other services and care and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or suffering from conditions which lead to crippling.	(1) $2,850,000 annually. (2) Secretary of Labor. (3) Allotments for any fiscal year are available until end of second succeeding fiscal year.	Funds available for half total cost of services planned: (1) $1,020,000, allotted $20,000 to each State. (2) $1,830,000, allotted according to need of each State as determined by Secretary of Labor after taking into consideration number of crippled children in such State in need of services and cost of furnishing services to them.	Same as A, above. (Funds available only for half total cost.)	Same as above.	State agency (type not specified).	(1) Financial participation by State. (2) Administration or supervision of administration by State agency. (3) Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for efficient operation of plan. (4) Provision for such reports by State agency as Secretary of Labor may require. (5) Provision for carrying out the purposes specified in the Act (sec. 511). [See column 1.] (6) Cooperation with medical, health, nursing, and welfare groups and organizations, and with any agency in State administering State laws for vocational rehabilitation of physically handicapped children.	Same as above.	
CHILD-WELFARE SERVICES (SEC. 521; TITLE V, PT. 3)								
Cooperation with State public-welfare agencies in establishing, extending, and strengthening (especially in predominantly rural areas) welfare services for protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent.	(1) $1,500,000 annually. (2) Secretary of Labor. (3) Allotments for any fiscal year are available until end of second succeeding fiscal year.	Funds available for payment of part of cost of district, county, or other local child-welfare services in areas predominantly rural and for developing State services for encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need. (1) $510,000, allotted $10,000 to each State. (2) $990,000, allotted on basis of ratio of rural population to total rural population of the United States.	Paid by Secretary of Treasury, on certification of Secretary of Labor, at such times as Secretary of Labor may designate.	Plans developed jointly by State agency and Children's Bureau.	State public-welfare agency.	Not prescribed.	No provision.	

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[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

TEXT OF THE SECTIONS OF THE ACT RELATING TO GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

Title V.—GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

Part 1.—MATERNAL AND CHILD HEALTH SERVICES

APPROPRIATION

Section 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $3,800,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 502. (*a*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and such part of $1,800,000 as he finds that the number of live births in such State bore to the total number of live births in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(*b*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to the States $980,000 (in addition to the allotments made under subsection (*a*)) according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of live births in such State.

(*c*) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 504 until the end of the second succeeding fiscal year. No payment to a State under section 504 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 503. (*a*) A State plan for maternal and child-health services must (1) provide for financial participation by the State; (2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State health agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for the extension and improvement of local maternal and child-health services administered by local child-health units; (6) provide for cooperation with medical, nursing, and welfare groups and organizations; and (7) provide for the development of demonstration services in needy areas and among groups in special need.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State health agency of his approval.

PAYMENT TO STATES

Sec. 504. (*a*) From the sums appropriated therefor and the allotments available under section 502 (*a*), the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(*c*) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 502 (*b*), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

OPERATION OF STATE PLANS

Sec. 505. In the case of any State plan for maternal and child-health services which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 503 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 2.—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

Sec. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $2,850,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 512. (*a*) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

(*b*) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 513. (*a*) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for carrying out the purposes specified in section 511; and (6) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

Sec. 514. (*a*) From the sums appropriated therefor and the allotments available under section 512, the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

OPERATION OF STATE PLANS

Sec. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 3.—CHILD-WELFARE SERVICES

Sec. 521. (*a*) For the purpose of enabling the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, public-welfare services (hereinafter in this section referred to as "child-welfare services") for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $1,500,000. Such amount shall be allotted by the Secretary of Labor for use by cooperating State public-welfare agencies on the basis of plans developed jointly by the State agency and the Children's Bureau, to each State, $10,000, and the remainder to each State on the basis of such plans, not to exceed such part of the remainder as the rural population of such State bears to the total rural population of the United States. The amount so allotted shall be expended for payment of part of the cost of district, county or other local child-welfare services in areas predominantly rural, and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need. The amount of any allotment to a State under this section for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under this section until the end of the second succeeding fiscal year. No payment to a State under this section shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

(*b*) From the sums appropriated therefor and the allotments available under subsection (*a*) the Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States, and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

* * * * * * *

Part 5.—ADMINISTRATION

Sec. 541. (*a*) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of $425,000, for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531.

(*b*) The Children's Bureau shall make such studies and investigations as will promote the efficient administration of this title, except section 531.

(*c*) The Secretary of Labor shall include in his annual report to Congress a full account of the administration of this title, except section 531.

* * * * * * *

Title XI.—GENERAL PROVISIONS

DEFINITIONS

Section. 1101. (*a*) When used in this Act—

(1) The term "State" (except when used in section 531) includes Alaska, Hawaii, and the District of Columbia.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

* * * * * * *

(*d*) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS

Sec. 1102. The Secretary of the Treasury, the Secretary of Labor, and the Social Security Board, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

SEPARABILITY

Sec. 1103. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act, and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

Sec. 1104. The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

Sec. 1105. This Act may be cited as the "Social Security Act."

9361.6-13

UNITED STATES
DEPARTMENT
OF LABOR

FRANCES PERKINS
Secretary

CHILDREN'S
BUREAU

KATHARINE F. LENROOT
Chief

Federal and State Cooperation in
Maternal and Child-Welfare Services

Under the Social Security Act

Maternal and
Child-Welfare
Bulletin No. 2

Summary for the 5 months ended June 30, 1936

Preliminary summary for the fiscal year 1937

UNITED STATES
GOVERNMENT
PRINTING OFFICE
WASHINGTON : 1938

UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, Secretary

CHILDREN'S BUREAU
KATHARINE F. LENROOT, Chief

FEDERAL AND STATE COOPERATION IN MATERNAL AND CHILD-WELFARE SERVICES UNDER THE SOCIAL SECURITY ACT

Title V, Parts 1, 2, and 3

Maternal and Child-Health Services
Services for Crippled Children
Child-Welfare Services

Summary for the 5 months ended June 30, 1936
Preliminary summary for the fiscal year 1937

Maternal and Child-Welfare Bulletin No. 2

For sale by the Superintendent of Documents, Washington, D. C. - - - - - - - - - - Price 15 cents

U. S. SUPERINTENDENT OF DOCUMENTS
JUN 3 1936

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LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, December 15, 1937.

MADAM: There is transmitted herewith Maternal and Child-Welfare Bulletin No. 2, Federal and State Cooperation in Maternal and Child-Welfare Services Under the Social Security Act, title V, parts 1, 2, and 3, providing for grants to the States for maternal and child-health services, services for crippled children, and child-welfare services. This bulletin includes an account of the administration of these parts of the act by the Children's Bureau during the first 17 months that the act was in operation (February 1, 1936, to June 30, 1937); a summary of State and local activities carried on under approved State plans in the 5-month period ended June 30, 1936; and a preliminary summary of such activities in the fiscal year ended June 30, 1937.

The members of the Children's Bureau staff who have been chiefly responsible for the administration of these programs are Martha M. Eliot, M. D., Assistant Chief of the Bureau; Albert McCown, M. D., the first Director of the Maternal and Child Health Division, and his successor, Edwin F. Daily, M. D.; Robert C. Hood, M. D., Director of the Crippled Children's Division; Mary Irene Atkinson, Director of the Child Welfare Division; Naomi Deutsch, R. N., Director of the Public Health Nursing Unit; and William J. Maguire, Director of the State Audits Unit.

Respectfully submitted.

KATHARINE F. LENROOT, *Chief.*

Hon. FRANCES PERKINS,
Secretary of Labor.

Federal and State Cooperation in Maternal and Child-Welfare Services Under the Social Security Act

△

FEDERAL ADMINISTRATION

Grants Authorized.

The Social Security Act, approved by the President August 14, 1935,[1] directed the Children's Bureau of the United States Department of Labor to administer the sections of the act providing for grants to the States (including Alaska, Hawaii, and the District of Columbia) to establish, extend, and improve (1) maternal and child-health services, (2) services for crippled children, and (3) child-welfare services. The act authorized the Secretary of Labor to make allotments and issue necessary regulations under these provisions.

The Social Security Act authorized annual appropriations for such grants, as follows:

Maternal and child-health services	$3, 800, 000
Services for crippled children	2, 850, 000
Child-welfare services	1, 500, 000
Total	8, 150, 000

Appropriations for Fiscal Year 1936.

An act of Congress, approved February 11, 1936,[2] made available the following appropriations for grants to States under title V, parts 1, 2, and 3, of the Social Security Act for the fiscal year ended June 30, 1936:

Maternal and child-health services	$1, 580, 000
Services for crippled children	1, 187, 000
Child-welfare services	625, 000
Total	3, 392, 000

This appropriation act provided that the allotments to the States for the fiscal year 1936 should be based on five-twelfths of the annual amounts authorized under the provisions of the Social Security Act and that no payment should be made to a State for any period prior to February 1, 1936. In other words, the first period of operation under the Social Security Act was the last 5 months of the fiscal year ended June 30, 1936.

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[1] Public, No. 271, 74th Cong.

[2] Public, No. 440, 74th Cong.

Children's Bureau Administrative Service.

Immediately after the passage of the Social Security Act the Children's Bureau began to make the preparations necessary for the administration of title V, parts 1, 2, and 3, of the act, providing for grants to the States, when funds should become available for this purpose. For each of the three programs provided for in the act a division was established in the Children's Bureau, namely, the Maternal and Child Health Division, the Crippled Children's Division, and the Child Welfare Division. All appointments in these divisions, as in all divisions of the Bureau, are made in accordance with civil-service regulations.

The Maternal and Child Health Division and the Crippled Children's Division, each of which is directed by a physician, receive general supervision from the Assistant Chief of the Children's Bureau, who is also a physician. A Public Health Nursing Unit, headed by a public-health nurse, was established to serve both the Maternal and Child Health Division and the Crippled Children's Division. The Child Welfare Division, with a social worker as director, receives general supervision from the Chief of the Children's Bureau. A State Audits Unit, under an accountant, was set up within the Bureau's Administrative Section to make the necessary check on budgets submitted as a part of State plans, to prepare computations showing Federal payments to be made, and to audit State funds used in matching Federal funds. Legal service is given by the office of the Solicitor of the Department of Labor.

The staffs of the three social-security divisions of the Children's Bureau include consultants in special fields of basic importance in each program. The Director of the Maternal and Child Health Division is an obstetrician, and the staff of this division includes physicians and a nutritionist. Two of the regional medical consultants are pediatricians; all have had experience in the maternal and child-health field and have been trained in public health. The Director of the Public Health Nursing Unit gives consultation service to this division and also to the Crippled Children's Division. The Director and Assistant Director of the Crippled Children's Division are pediatricians with experience in work for crippled children, and the staff of this division includes a consultant orthopedic surgeon and medical social workers. In the Child Welfare Division are social workers experienced in the fields of State administration and community organization of child-welfare services. A statistical consultant provides advisory service to these three divisions on the development of records and statistical reports of State and local activities. These divisions make use also of the information and advice of the specialists in the research divisions of the Bureau, especially those in the Division of Research in Child Development, the Social Service Division, and the Delinquency Division.

To facilitate field service five regions have been marked out, which include, with some variations, the Northeastern States; the Southeastern States; the North Central States; the South Central States; and the Western States, Alaska, and Hawaii. A regional office was established in San Francisco in May 1936, and one in New Orleans in September 1936. The other regions are served from the Washington office.

To give assistance to the State agencies there is assigned to each region a medical consultant, a public-health-nursing consultant, a social-work consultant, and an auditor.

The Social Security Act authorized an appropriation of $425,000 for the fiscal year ended June 30, 1936, for the expenses of the Children's Bureau in administering the parts of the act relating to maternal and child-health services, services for crippled children, and child-welfare services. The sum so authorized for administrative expenses was 5.2 percent of the total amount authorized for Federal grants to the States for these three types of service. Under this authorization $150,000 was appropriated for such administrative expenses for the last 5 months of the fiscal year ended June 30, 1936 (act approved Feb. 11, 1936), with the proviso that this appropriation should be available to cover administrative expenses paid between August 14, 1935, and February 11, 1936, in performance of the duties imposed on the Children's Bureau by the Social Security Act. For appropriations for this purpose for the fiscal years 1936, 1937, and 1938 see table 1.

TABLE 1.—*Amounts authorized for annual appropriation by the Social Security Act, title V, parts 1, 2, 3, and 5, and appropriations made by Congress for the fiscal years ending June 30, 1936, 1937, and 1938*

Purpose	Amounts authorized for annual appropriation	Appropriations [1]		
		Fiscal year 1936 (Feb. 1–June 30)	Fiscal year 1937	Fiscal year 1938
Grants to States:				
For maternal and child-health services	$3, 800, 000	$1, 580, 000	[2] $2, 820, 000	[2] $3, 700, 000
For services for crippled children	2, 850, 000	1, 187, 000	[2] 2, 150, 000	[2] 2, 800, 000
For child-welfare services	1, 500, 000	625, 000	[2] 1, 200, 000	[2] 1, 475, 000
Administrative expenses, Children's Bureau	(3)	[4] 150, 000	299, 000	[5] 306, 000

[1] These appropriations were made as follows: For the fiscal year 1936, Public, No. 440, 74th Cong.; for the fiscal year 1937, Public, No. 599, 74th Cong.; for the fiscal year 1938, Public, No. 153, 75th Cong.

[2] This amount is smaller than the annual amount authorized in the Social Security Act, but the appropriation act simultaneously authorized allotments to the States on the basis of the total amount authorized in the Social Security Act.

[3] $425,000 was authorized for this purpose for the fiscal year 1936. No amount was specified for succeeding years.

[4] This appropriation was also available for reimbursement of the Children's Bureau for administrative expenses incurred in performance of duties imposed by the Social Security Act between Aug. 14, 1935, and the passage of the appropriation act.

[5] In addition, $70,000 has been allotted to the Children's Bureau for travel expenses from the consolidated travel fund for the Department of Labor (consolidated in one fund for the year 1938 for the first time).

Cooperation With Other Federal Agencies.

In administering the three maternal and child-welfare programs the Children's Bureau proceeds in frequent consultation with other Federal agencies that are responsible for related programs. Policies governing the administration of grants for maternal and child-health services and for services for crippled children are developed by the Children's Bureau in the light of the policies of the United States Public Health Service relating to grants-in-aid to the States for public-health services. In connection with the crippled children's program the Children's Bureau consults as necessary with the Vocational Rehabilitation Service of the Office of Education, United States Department of the Interior, which administers Federal grants to the States for the vocational rehabilitation of the physically disabled. In connection with the program for child-welfare services the Children's Bureau works closely with the Bureau of Public Assistance of the Social Security Board, which administers grants to States for aid to dependent children, and cooperates with the social-service staff of the Works Progress Administration.

Advisory Service on Policies and Procedure.

A general advisory committee and an advisory committee for each of the three special fields of activity have been appointed by the Secretary of Labor to advise the Children's Bureau and the States on policies to be followed in formulating plans for carrying out the purposes of title V, parts 1, 2, and 3, of the Social Security Act.

The general advisory committee on maternal and child-welfare services, with Kenneth D. Blackfan, M. D., as chairman, includes professional and lay members, a number of them representing national organizations. The special committees are entirely made up of professional members. The chairman of the advisory committees on the three programs are as follows: advisory committee on maternal and child-health services, Henry F. Helmholz, M. D.; advisory committee on services for crippled children, Albert H. Freiberg, M. D.; and advisory committee on community child-welfare services, H. Ida Curry.

The general committee and the three special committees met on December 16 and 17, 1935. Each special committee presented recommendations on its program, which were accepted and endorsed by the general committee. These recommendations were invaluable to the Children's Bureau and the State agencies in the working out of policies incorporated in the State plans for the three services under the Social Security Act.

In anticipation of the development of plans for the fiscal year 1937 two of the special committees met again toward the close of the period of operation of the State plans for the fiscal year 1936. The advisory committee on community child-welfare services held its second meeting on June 1, 1936, and amplified the recommendations that it had made in the previous December. The advisory committee on maternal and child-health services held its second meeting June 5 to discuss the problems brought to light during the initial period of operation under the State plans.

As plans progressed prior to the time when funds became available, the need for a special Children's Bureau advisory committee on maternal welfare had become evident. A first meeting of a group of obstetricians was held in March 1936, and as a result a continuing committee was appointed by the Secretary of Labor, who selected as its chairman Fred L. Adair, M. D., the chairman of the American Committee on Maternal Welfare.

A special advisory committee on training and personnel problems in the field of child welfare was appointed by the Secretary of Labor, with Walter Pettit as chairman; and its first meeting was held October 19, 1936. The same committee serves the Bureau of Public Assistance of the Social Security Board.

The general advisory committee on maternal and child-welfare services held its second meeting with the advisory committees for each of the three programs on April 7 and 8, 1937.

The recommendations made by the advisory committees are discussed in the sections that follow. The committee membership is given in appendix 3, page 107.

Conferences of State Officials.

The State and Territorial health officers performed a valuable service to the Children's Bureau and the States when in June 1935, in anticipation of the passage of the Social Security Act, they adopted an outline or plan for the development of maternal and child-health programs, including public-health-nursing and dental programs. The plan was expanded and somewhat revised at the conference of the State and Territorial health officers held with the Children's Bureau April 15, 1936.

By April 1936 in a considerable number of States the health department had been designated as the agency to administer the program for services for crippled children. In other States it was apparent that the State and local health departments would be called upon to perform important cooperative services in relation to this program. At the April 1936 conference, accordingly, the State and Territorial health officers adopted recommendations on standards and administrative organization of State programs of services for crippled children. For a summary of the recommendations of the State and Territorial health officers see page 15.

A conference on the administration of child-welfare services was held at the Children's Bureau June 1 and 2, 1936. Invitations were sent to the directors of public welfare of all the States, and each was asked to send an official delegate to the meeting, preferably the person responsible for the direction of child-welfare services in the State. The conference was attended by representatives from 43 States, the District of Columbia, and Hawaii, and by members of the advisory committee on community child-welfare services.

A similar conference of the directors of maternal and child-health divisions in State departments of health was held at the Children's Bureau on June 6 and 7, 1936, to discuss the administration of maternal and child-health services. Forty-one States, the District of Columbia, Alaska, and Hawaii were represented by maternal and child-health directors. Four other States were represented by their State health officers or by other officials from the State department of health.

Allotments to States.

For the first three parts of title V the Social Security Act specifies the basis for the allotment of Federal grants to the States and places upon the Secretary of Labor the responsibility for making the actual allotment to each State.

Maternal and child-health services.—For grants to the States for maternal and child-health services the Social Security Act authorizes an annual appropriation of $3,800,000. It provides (1) that $20,000 shall be allotted to each State (total $1,020,000) and (2) that each State shall be allotted a part of $1,800,000 based on the ratio of its live births to the total number of live births in the latest calendar year for which census figures are available. These amounts (total $2,820,000, designated for administrative purposes as fund A) are made available for paying one-half of State and local expenditures for maternal and child-health services under State plans approved by the Chief of the Children's Bureau. The act provides also that $980,000 (designated as fund B) shall be allotted to the States according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary of Labor after taking into consideration the number of live births in the State.

The first appropriation for grants to the States for maternal and child-health services, made for the last 5 months of the fiscal year 1936, was $1,580,000, approximately five-twelfths of the annual sum authorized.

Of this appropriation, $1,172,518 (fund A) was available for matching State and local expenditures. From this fund the Secretary of Labor allotted to each State $8,315.69 (about five-twelfths of $20,000) and in addition a share of the balance, $748,417.81, in the proportion that the number of live births in the State bore to the total number in the United States in 1934, the latest year for which census figures were then available.

Owing to delays in the submission and approval of State plans and, in some cases, to limited State and local appropriations for maternal and child-health services, only $952,404.70 was paid to the States by June 30, 1936, out of the total of $1,172,518 available for paying one-half of State and local expenditures. The balance, $220,113.30, is available under the terms of the act for payment to the States until June 30, 1938. No payment from the allotment for any fiscal year may be paid to a State until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

The appropriation for the fiscal year 1936 included $407,482 (fund B), to be allotted according to the financial need of each State for assistance in carrying out its State plan. The Secretary of Labor made a conditional distribution of this fund as follows:

1. A uniform apportionment of $2,078.99 to each State, the total amount apportioned to the States being $106,028.49.
2. The sum of $99,791.50, to be divided among the States after taking into consideration excessive infant mortality and the number of live births in each State.
3. The sum of $99,791.50, to be divided among the States after taking into consideration excessive maternal mortality and the number of live births in each State.
4. The sum of $101,870.51, to be divided among the States on the basis of the sparsity of population.

After the conditional allotment for each State was so determined, the Secretary of Labor compared it with the amount requested by each State on the basis of its need for financial assistance in carrying out its plan. She found it possible to allot to 40 States the full amount shown by the States to be needed and to make a conditional allotment to 7 States from which complete detailed information had not been received. Four States had indicated that they were making no request for an allotment from this fund (fund B). The final allotment was made on February 18, 1936.

On account of delays in the submission and approval of State plans, State requests amounted to less than the total appropriated for fund B. The actual payments to the States from this fund for the fiscal year 1936 totaled $300,031.52. The balance ($107,450.48) ceased to be available for payment to the States on June 30, 1936.

Services for crippled children.—For grants to States for services for crippled children, the Social Security Act authorizes an annual appropriation of $2,850,000. It provides (1) that $20,000 shall be allotted to each State (total $1,020,000) and (2) that the remainder ($1,830,000) shall be allotted to the States according to the needs of each State as determined by the Secretary of Labor after taking into consideration the number of crippled children in such State in need of services and the cost of furnishing such services to them.

The first appropriation for grants to the States for services for crippled children ($1,187,000) for the 5-month period, February 1 to June 30, 1936, was approximately five-twelfths of the annual sum authorized by the act. The Secretary of Labor allotted $8,329.95 to each State. The balance of the fund was divided into two parts. The sum of $595,506 was apportioned according to the number of persons under 21 years of age in each State in proportion to the total population of the United States under 21. This apportionment was based on the estimated number of crippled children in the population, assuming a uniform average of 6 crippled children per 1,000 population under 21 years of age for the entire country. Of the $166,666.55 remaining $76,154.64 was allotted after the States had sent in reports showing the number of crippled children not provided for, the need for care arising out of acute epidemics of poliomyelitis, and increased costs of care.

The act provides that the payments to the States for services for crippled children shall be equal to one-half the total sum expended for carrying out the State plan. In other words, to receive the full amount offered a State must have available for services for crippled children an equal sum from State or from State and local sources.

The States were not all able to submit their plans in time for approval by June 30, and some were unable to match in full the Federal aid offered. The total paid to the States to June 30, 1936, was $732,492.33; the balance ($454,507.67) is available for payment to the States until June 30, 1938.

Child-welfare services.—For grants to the States for child-welfare services, the Social Security Act authorizes an annual appropriation of $1,500,000, to be allotted by the Secretary of Labor to the States on the basis of plans developed jointly by the State agency and the Children's Bureau. The Secretary of Labor is directed to allot $10,000 to each State and the remainder to each State on the basis of such plans, not to exceed such part of the remainder as the rural population of such State bears to the total rural population of the United States.

The 1936 appropriation of $625,000 was sufficient to permit the allotting to each State of $4,166.67 and a share of $412,499.83 on the basis of the ratio of its rural population to the total population of the United States. Because of lack of definite administrative organization for child-welfare services some States could not qualify for the grant for this purpose by the end of the fiscal year 1936. The sum of $227,954.12 was paid to the States that qualified by June 30. The amount available for allotment to the States but remaining unpaid at the end of the fiscal year 1936 (total $180,865.19) is available for payment to such States until June 30, 1938.

Submission and Approval of State Plans.

Soon after the passage of the Social Security Act the Children's Bureau began conferring with the States on the preparation of State plans for the three programs to be submitted to the Chief of the Children's Bureau for approval.

Forms for State plans were provided by the Children's Bureau for the use of the State agencies. The forms for each program called for a description of how the State agency proposed to extend and improve services in accordance with the requirements of the Social Security Act and a budget showing the estimated expenditures necessary to carry on the proposed services, including the Federal funds requested. Forms for certificates of various officials were also included.

Questions immediately arose in relation to each program in each State.

The first question was: What State agency had the authority to submit a State plan and to request the Federal aid offered?

This was readily answered in regard to maternal and child-health services, as the Social Security Act provided for administration by the State health agency, and each State and Territory had such an agency.

With regard to services for crippled children it was necessary for State officials to determine what State agency was legally authorized to render such services or for the Governor to issue an executive order designating the agency authorized to submit a plan.

With regard to the program for child-welfare services the Social Security Act specified cooperation with State public-welfare agencies. In a few States either there was no department of public welfare or the public-welfare agency had no legal responsibility for services for children. In such States legislation was necessary before the State could be in a position to cooperate with the Children's Bureau in the preparation of a plan for child-welfare services.

In each case the State agency submitted with its plan copies of the laws, executive orders, or other documents showing the legal authority under which it was acting and a certificate of the attorney general that such laws or orders were valid and in effect.

Another question that arose with regard to the maternal and child-health and crippled children's programs was whether the States and their local governments had for each type of program appropriations available for matching the Federal funds offered, as required by the act. As evidence that State appropriations were available a certificate to that effect from the State treasurer was submitted. Where local governmental funds were to be used in matching the Federal funds, it was necessary to make sure that the local funds were to be used for the services and facilities described in the State plan under the supervision of the State agency. To safeguard this the executive officer of the official State agency was asked to certify that this was to be done.

For grants for child-welfare services, the Social Security Act does not require the matching of Federal funds with State and local funds on a specified basis. It does provide that the Federal grant is to be expended for the payment of "part of the cost of district, county, or other local child-welfare services * * * and for developing State services for the encouragement * * * of community child-welfare organization * * *." No State expenditure is required for child-welfare services, and, therefore, it was not necessary to ask for a State treasurer's certificate of State funds available, as was done for the other two programs. It was sufficient to ask that the executive officer of the State public-welfare agency certify that the budget submitted was based on the availability of State and local funds for the services and facilities described in the plan.

An important part of each State plan is the "descriptive plan", in which the State agency explains the State and local activities already being carried on and sets forth the plan for extending and improving existing services and for establishing new services. The descriptive plan for each type of service shows how the State proposes to conform to the requirements of the Social Security Act, which must be met if the State is to qualify to receive the Federal grant.

State officials also submit as part of their State plans budgets showing the estimated expenditures to carry on the proposed services, thus showing the relation of the descriptive plan to the request for the grant of Federal funds to match or supplement State and local funds.

After a State plan is approved by the Chief of the Children's Bureau, the Secretary of Labor certifies to the Secretary of the Treasury the amount to be paid to the State. Table 2 shows the date of approval of each of the first State plans.

TABLE 2.—*Date of approval by Chief of Children's Bureau of first State plans under the Social Security Act, title V, parts 1, 2, and 3*

State [1]	Date of approval of State plans (1936 unless otherwise noted)		
	Part 1, Maternal and child-health services	Part 2, Services for crippled children	Part 3, Child-welfare services
Alabama	Mar. 7	Mar. 5	Feb. 21.
Alaska	Mar. 30	Mar. 28	(2).
Arizona	Apr. 7	do	May 8.
Arkansas	Mar. 7	(2)	Sept. 4.
California	Apr. 3	Mar. 25	June 10.
Colorado	May 21	May 21	Aug. 8.
Connecticut	Feb. 17	(2)	July 28.
Delaware	Apr. 2	(2)	May 8.
District of Columbia	Apr. 11	June 27	Do.
Florida	Mar. 3	Mar. 20	Mar. 25.
Georgia	Apr. 9	Jan. 19, 1937	Sept. 4.

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.
[2] State plan not approved up to June 30, 1937.

TABLE 2.—*Date of approval by Chief of Children's Bureau of first State plans under the Social Security Act, title V, parts 1, 2, and 3*—Con.

State [1]	Date of approval of State plans (1936 unless otherwise noted)		
	Part 1, Maternal and child-health services	Part 2, Services for crippled children	Part 3, Child-welfare services
Hawaii	Mar. 10	Oct. 20	(2).
Idaho	Mar. 14	Mar. 20	Mar. 16.
Illinois	July 2	Jan. 4, 1937	July 13.
Indiana	May 20	Jan. 12, 1937	Aug. 11.
Iowa	Apr. 8	Aug. 3	Aug. 8.
Kansas	Feb. 17	Apr. 3	Mar. 24.
Kentucky	Mar. 6	Feb. 26	Mar. 9, 1937.
Louisiana	Mar. 25	(2)	June 13.
Maine	Feb. 17	Feb. 26	Mar. 20.
Maryland	Mar. 10	Aug. 1	Mar. 24.
Massachusetts	Feb. 17	June 27	June 26.
Michigan	Mar. 5	Feb. 26	Apr. 7.
Minnesota	Feb. 19	Apr. 16	Mar. 16.
Mississippi	Mar. 18	June 17	(2).
Missouri	Mar. 30	Mar. 23	Mar. 20.
Montana	Mar. 20	Apr. 6	Apr. 28.
Nebraska	Mar. 21	June 18	Apr. 7.
Nevada	May 11	(2)	May 18.
New Hampshire	Mar. 18	May 19	Mar. 6.
New Jersey	Apr. 25	Apr. 25	May 18.
New Mexico	Feb. 21	Apr. 7	Mar. 18.
New York	Feb. 17	Apr. 3	May 12, 1937.
North Carolina	Apr. 3	Apr. 9	Apr. 7.
North Dakota	June 15	Nov. 25	Oct. 21.
Ohio	Mar. 14	June 20	June 18.
Oklahoma	Apr. 7	Mar. 16	May 18.
Oregon	Nov. 25	(2)	June 11.
Pennsylvania	June 1	June 19	Apr. 7.
Rhode Island	Apr. 7	Mar. 28	(2).
South Carolina	Mar. 24	Mar. 13	(2).
South Dakota	Feb. 17	Apr. 2	Mar. 21.
Tennessee	Mar. 24	Mar. 14	Apr. 23, 1937.
Texas	Mar. 30	Mar. 20	Apr. 7.
Utah	June 30	July 1	Mar. 13.
Vermont	May 19	Mar. 6	Mar. 9.
Virginia	Apr. 8	Apr. 18	Mar. 24.
Washington	Feb. 17	Apr. 2	Mar. 21.
West Virginia	do	Mar. 11	Apr. 7.
Wisconsin	Mar. 7	Mar. 17	Do.
Wyoming	Mar. 6	Mar. 6	(2).

[1] The term "State," includes Alaska, Hawaii, and the District of Columbia.
[2] State plan not approved up to June 30, 1937.

Services to Special Areas and Special Groups.

The Social Security Act directs emphasis on service to special groups or special areas for the three programs administered by the Children's Bureau, as follows:

> Maternal and child-health services—"especially in rural areas and in areas suffering from severe economic distress," and "the development of demonstration services in needy areas and among groups in special need."
>
> Services for crippled children—"especially in rural areas and in areas suffering from severe economic distress."
>
> Child-welfare services—local "child-welfare services in areas predominantly rural," and State services for the "encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need."

The State health agencies, in making their maternal and child-health plans, provided first for extending service to rural areas through county or district health units where organized, or through placing public-health nurses in counties to work primarily in the rural areas and the smaller towns. Provision of such service in all rural areas is the goal to be approached as more State and local funds become available for this purpose. Areas of economic distress are provided for in the State plans through the granting of funds to pay, in whole or in part, the salaries of local health workers or through the placing of State personnel in areas pending the time when the county or the local subdivision can meet the cost or share it. Groups in special need are provided for in State plans for the most part through establishing demonstration services under State direction in areas where the maternal or infant mortality is high and through special services, such as a mobile tuberculosis unit in New Mexico and a service for migratory crop workers in California. Frequently "groups in special need" are found in areas of economic distress.

Crippled children's services, under the State plans, are extended to rural areas and areas suffering from severe economic distress through locating crippled children throughout the State, holding diagnostic and treatment clinics periodically in centers accessible to crippled children and arranging for surgical and hospital care and for after-care service.

The Children's Bureau and the State public-welfare agencies, in making State plans for child-welfare services, have emphasized throughout the provision of service in rural areas. Limited funds make it necessary in most States for these services to be set up in a selected area, chosen in part, at least, by reason of special need, as a demonstration of services that might well be available throughout the State.

Although special attention has been directed in each State toward observing these requirements of the act, other areas also will benefit from the program. The two major benefits that will reach mothers and children in all parts of the State are: (1) The stronger State service that the State administrative agency will be able to render to all areas and (2) the stimulus and the knowledge tested by experience that will spread to all communities in the State as they observe the progress of services and demonstrations in selected areas.

The Starting Point—Recommendations of the Committee on Economic Security.

In providing for the three maternal and child-welfare programs title V of the Social Security Act embodied in law the recommendations that the President's Committee on Economic Security made in January 1935. This committee's statement in support of its recommendations revealed the need for the new services and defined the goals to be sought. It is appropriate to introduce the succeeding parts of this report, which describe progress made toward those goals, by quoting the committee's report to the President:

> Local services for the protection and care of dependent and physically and mentally handicapped children are generally available in large urban centers, but in less populous areas they are extremely limited or even nonexistent. One-fourth of the States only have made provisions on a State-wide basis for county child-welfare boards or similar agencies, and in many of these States the services are still inadequate. With the further depletion of resources during the depression there has been much suffering among many children because the services they need have been curtailed or even stopped. To counteract this tendency and to stimulate action toward the establishment of adequate State or local child-welfare services, a small Federal grant-in-aid, we believe, would be very effective.
>
> The fact that the maternal mortality rate in this country is much higher than that of nearly all other progressive countries suggests the great need for Federal participation in a Nation-wide maternal and child-health program. From 1922 to 1929 all but three States participated in the successful operation of such a program. Federal funds were then withdrawn, and as a consequence State appropriations were materially reduced. Twenty-three States now either have no special funds for maternal and child health or appropriate for this purpose $10,000 or less. In the meantime the need has become increasingly acute.
>
> Crippled children and those suffering from chronic disease such as heart disease and tuberculosis constitute a regiment of whose needs the country became acutely conscious only after the now abandoned child- and maternal-health program was inaugurated. In more than half the States some State and local funds are now being devoted to the care of crippled children. This care includes diagnostic clinics, hospitalization, and convalescent treatment. But in nearly half the States nothing at all is now being done for these children, and in many the appropriations are so small as to take care of a negligible number of children. Since hundreds of thousands of children need this care the situation is not only tragic but dangerous.
>
> We recommend that the Federal Government through the agency of the Children's Bureau should again assume leadership in a Nation-wide child- and maternal-health program. Such a program should provide for an extension of maternal- and child-health services, especially in rural areas. It should include: (*a*) Education of parents and professional groups in maternal and child care; supervision of the health of expectant mothers, infants, preschool and school children, and children leaving school for work; (*b*) provision for transportation, hospitalization, and convalescent care of crippled children in areas of less than 100,000 population. This program should be developed in the States under the leadership of the State departments of health in cooperation with medical and public-welfare agencies and groups concerned with these problems. Federal participation is vital to its success. It should take the form both of grants-in-aid and of consultative, educational, and promotional work by the Children's Bureau in cooperation with the State health departments.[3]

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[3] Report to the President of the Committee on Economic Security, Jan. 15, 1935, pp. 37–38. Washington, 1935.

MATERNAL AND CHILD-HEALTH SERVICES[1]

Part 1 of title V of the Social Security Act authorizes an annual appropriation of $3,800,000 for grants to the States to enable each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.

The first appropriation for grants to the States for these purposes was $1,580,000, for the period February 1 to June 30, 1936. (See p. 1.)

Children's Bureau Administrative Service.

The Maternal and Child Health Division of the Children's Bureau, under the direction of a physician, was placed in immediate charge of the administration of this part of the Social Security Act. A major function of the division is to provide consultation service to the State public-health agencies in the formulation of State plans and in the conduct of State programs. The director of the division and the regional medical consultants advise the State health officer and the State maternal and child-health director with reference to the preparation of the State plan, and throughout the year confer with them on the development of the program and on the administrative and medical phases of the service being rendered.

The Director of the Public Health Nursing Unit and the regional nursing consultants give advice on the nursing aspects of maternal and child-health services to State health officials, including the public-health nurses in the public-health-nursing bureau of the State department of health, in States where such a bureau exists, or on the staff of the bureau of maternal and child health.

Similarly the Director of the Maternal and Child Health Division gives the State agencies assistance on the maternal-health phases of the State program; the consultant in nutrition on the development of nutrition service in the program and on the inclusion of nutrition in the training given public-health nurses and other health workers; and the statistical consultant on records and reports.

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[1] The information in this section is for the fiscal year 1936 (5 months, Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

Advisory Service.

The Children's Bureau advisory committee on maternal and child-health services in December 1935 made a series of recommendations to guide the Children's Bureau and the States in the development of these services. One of these recommendations was that State agencies in making their plans give careful consideration to the recommendations made by the conference of the State and Territorial health officers relating to local, State, and Federal programs for these services.

The major features of the recommendations of the State and Territorial health officers were as follows:

MATERNAL AND CHILD-HEALTH PROGRAM

Emphasis: On the development of certain minimum health services for mothers and children who are unable to obtain them otherwise and on State and local programs for the education of lay and professional groups in the essentials of adequate maternal and child care.

LOCAL MATERNAL AND CHILD-HEALTH PROGRAM

1. Maternal, infant, and preschool services.
    - *a.* In permanent conferences located in the center or centers of population of the county or district.
    - *b.* In regular itinerant conferences reaching out from such centers to rural areas of the county or district.
    - *c.* In physicians' or dentists' offices when this is found to be practicable and advisable by health and medical organizations.
2. School health services, including health examinations and health-education programs—to be provided preferably by local physicians through local departments of health or of education, or both, in cooperation with medical societies in the community.
    - *a.* Health examinations (including dental examinations) of all children on entering school and at stated intervals thereafter, and of other children as indicated.
    - *b.* Follow-up for correction of defects.
3. Health services for children entering employment or at work.
4. Health services for special groups of children—handicapped, in institutions, on relief—in cooperation with social-welfare agencies.
5. Public-health-nursing service for mothers and for children of all ages.
    - *a.* As part of the generalized service of the official county or district health units, primarily an educational and demonstration program, including—
        - (1) Home visiting;
        - (2) Service at prenatal and child-health conferences;
        - (3) Assisting at school health examinations and in securing correction of defects; and
        - (4) Cooperation with physicians, agencies, and workers in connection with health supervision of individuals, and community organization for improved health services for all mothers and children.
    - *b.* Maternity-nursing service for care of mothers at delivery and postpartum, bedside nursing service, and an educational program in maternal care for the women of the county and local community.

As part of a preventive medical program and in cooperation with local medical societies and with nursing, welfare, and social-service groups, it should be the responsibility of physicians conducting a health service to see that provision for adequate care for the sick is made, including correction of remediable defects, by private physicians or dentists or through appropriate welfare agencies.

A continuing program of education in the essentials of adequate maternal and child care should be developed by local county or community health services in cooperation with medical organizations, education authorities, nutritionists, and others. Though such a program of education is probably carried out most effectively in the form of individual instruction by physicians and nurses, it should also include health instruction in schools, group instruction of adults, community organization for the establishment or improvement of health services for mothers and children, and distribution of printed matter on maternal and child health, emphasizing preventive measures, health habits, nutrition, and general standards of good care. Education in the field of mental health may be developed through any of these channels as qualified personnel becomes available for this aspect of the health program.

STATE-WIDE MATERNAL AND CHILD-HEALTH PROGRAM—DIVISION OF MATERNAL AND CHILD HEALTH

Status: There should be a division of maternal and child health in each State and Territorial department of health, coordinate with all major administrative divisions and in charge of a full-time director responsible to the State health officers. Such a division should provide leadership for the development of local health services for mothers and children.

Functions (primarily advisory and educational):

1. To assist local communities in the development of maternal and child-health services through—
   - *a.* Consultation with and guidance of local communities in planning and developing their services for mothers and children, including supervision of methods and technique of procedures employed.
   - *b.* Demonstration of services in local communities for which personnel or funds may need to be provided.
   - *c.* Assistance in the provision of permanent services in localities in special need by providing funds or personnel or both.

   Where State and Federal funds are available for local purposes the State health agency through its division of maternal and child health will assist in formulating plans and have the power of approval of such plans.

2. To develop, in collaboration with medical organizations and with local health units, an educational program to reach both lay and professional groups and organizations through—
   - *a.* State-wide planning for the education of parents and lay groups in the essentials of adequate maternal and child care, with emphasis on the means of obtaining these essentials through health departments, local physicians, and other agencies.
   - *b.* Continuous staff-education program in maternal and child health for all State and local public-health personnel, including special postgraduate work in maternal and child health.
   - *c.* Cooperation with professional groups and associations (medical, dental, nursing, social-welfare, education, home-economics, and others) in the development of a continuing program of education for these groups to bring to them current knowledge in the fields of pediatrics and obstetrics and its practical application in the program of maternal and child health.

d. Continued instruction of midwives, with gradual raising of standards of licensing.

e. Cooperation with departments of public instruction and other educational groups in a program of education of students in high schools, vocational schools, normal schools, or colleges in the essentials of maternal and child care.

Personnel:

Medical personnel: Full-time medical director; additional medical staff for consultation and advisory service, the size of the staff depending on the needs of the State; and part-time regional consultants in the fields of pediatrics and obstetrics.

Nursing personnel assisting in the maternal and child-health program: Director of public-health nursing or chief nurse; educational director; specialized supervisor; generalized supervisor; staff nurse.

Special staff to be added in the following fields as the program develops: Dentistry and dental hygiene, nutrition, health education, mental hygiene, and posture training.

FEDERAL PARTICIPATION WITH THE STATES

The function of the Federal administrative bureau (the Children's Bureau) with respect to maternal and child-health services under the Social Security Act is primarily consultative, with the power of approval of plans made by State departments of health receiving Federal funds for maternal and child-health programs. Furthermore, the Children's Bureau in its relationships with the States has additional functions as follows:

1. To provide consultation and advisory service to the State departments of health with respect to conduct of the maternal and child-health programs, administrative procedures, budgeting, and accounting problems.
2. To assist States in building up well-staffed divisions of maternal and child health and public-health nursing and, through such divisions, to improve services to mothers and children in local communities.
3. To cooperate with State health departments and medical organizations in demonstrations of special maternal and child-health services and in the provision of certain types of professional education.
4. To undertake research and conduct investigations or demonstrations that cannot be conducted by individual States or communities, relating to the health or mortality of mothers and children or to improvement in methods of care.
5. To promote joint activities in various phases of child health and welfare; for example, community demonstrations in the field of delinquency and its relation to mental health and recreation, studies of the health of children entering employment and of other problems affecting child health and welfare.

On March 14, 1936, on invitation of the Secretary of Labor and the Chief of the Children's Bureau, the following members of the American Committee on Maternal Welfare, with Dr. Fred L. Adair as chairman, met at the Children's Bureau: Drs. Fred L. Adair, James R. McCord, Philip F. Williams, Everett D. Plass, Lyle G. McNeile, George W. Kosmak. Members of the staff of the Children's Bureau presented details of maternal-welfare features of State plans. The following topics were discussed by the committee: Teaching programs, development of special maternity demonstrations, methods of cooperation between the Children's Bureau and the State health departments, and functions of advisory committees. The committee also discussed the organization of maternal-welfare committees of State medical societies under the auspices of the American Committee on Maternal Welfare. After this meeting the Secretary of Labor appointed the special advisory committee on maternal welfare mentioned on page 5.

Submission and Approval of State Plans.

Each State plan, before it can be approved by the Chief of the Children's Bureau, must comply with the conditions specified in section 503 (*a*) of the Social Security Act. These conditions are as follows:

1. Financial participation by the State.
2. Administration of the plan or supervision of administration of the plan by the State health agency.
3. Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan.
4. Provision for such reports by the State health agency in such form and containing such information as the Secretary of Labor may from time to time require and for compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports.
5. Provision for extension and improvement of local maternal and child-health services.
6. Provision for cooperation with medical, nursing, and welfare groups and organizations.
7. Provision for development of demonstration services in needy areas and among groups in special need.

In each State plan submitted the "descriptive plan" explained the State and local administrative public-health organization for rendering maternal and child-health services, the proposed administrative expansion, the existing maternal and child-health activities, the plan for improving and extending such services, and other data showing compliance with the conditions specified in the Social Security Act. The second part of each plan was the budget, which showed (1) the State and local funds available and the Federal funds requested and (2) the estimated expenditures for State and local maternal and child-health services and indicated whether Federal, State, or local funds were to be used for each expenditure proposed.

The carrying out of proposals in the State plans for local maternal and child-health services was necessarily dependent upon the State health agency's obtaining the cooperation of local governing boards and public-health agencies and of local physicians, whose assistance is essential to the conduct of such services.

The first legal problem that arose in regard to each State was to identify "the State health agency," which, according to the terms of the act, was to administer the plan or to supervise its administration. In most States there was no difficulty, because the State board of health or the State department of health was clearly the State health agency vested with authority to render maternal and child-health services. In a few States legislation was enacted authorizing cooperation with the Federal Government under the Social Security Act, in general terms that cover all parts of the act, and designating one State agency to administer the cooperative services so authorized. In States where such a law failed to take cognizance of the fact that the Social Security Act requires that the grant for maternal and child-health services should be administered by the State health agency, it was necessary to call upon the State attorney general to rule upon the laws involved and to determine whether the authority to proceed with the program in question was vested in the State department of health.

In reviewing each State plan before approval by the Chief of the Children's Bureau, it was determined whether the plan provided for the extension and improvement of local maternal and child-health services as required by the act. This point will be of significance each year, when the States submit their plans, as it will be necessary each year to show extension and improvement of maternal and child-health services.

For the 5-month period ended June 30, 1936, the State health agencies of all the 48 States, Alaska, Hawaii, and the District of Columbia submitted plans for maternal and child-health services. Of the 51 plans submitted, 49 were approved and were in operation as of June 30, 1936; consideration of the other two plans was not completed. Illinois elected to wait until the beginning of the fiscal year 1937 to begin operation. In Oregon legal problems arose so that approval of the plan was delayed.[2]

Allotments and Payments to States.

Table 3 shows the allotments and payments made to the 48 States, Alaska, Hawaii, and the District of Columbia for maternal and child-health services for the 5-month period ended June 30, 1936.

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[2] For the fiscal year 1937 the Illinois plan was approved July 2, 1936; the Oregon plan Nov. 25, 1936.

TABLE 3.—*Allotments and payments to States for maternal and child-health services under the Social Security Act, title V, part 1, 5 months ended June 30, 1936*

State [1]	Allotment				Payment [2]		
	Total	FUND A Available for payment of half the total expenditures (except from fund B) under approved plans [3]		FUND B Allotment on basis of need for assistance in carrying out State plan, after number of live births is taken into consideration	Total	FUND A	FUND B
		Uniform allotment	Allotment on basis of ratio of live births in State to total live births				
Total	$1,579,968.83	$424,100.19	$748,417.81	$407,450.83	$1,252,436.22	$952,404.70	$300,031.52
Alabama	45, 100. 87	8, 315. 69	21, 816. 45	14, 968. 73	45, 100. 68	30, 132. 04	14, 968. 64
Alaska	14, 992. 46	8, 315. 69	439. 80	6, 236. 97	6, 364. 06	1, 366. 67	4, 997. 39
Arizona	20, 924. 85	8, 315. 69	2, 917. 79	9, 691. 37	18, 261. 58	9, 001. 58	9, 260. 00
Arkansas	30, 768. 94	8, 315. 69	12, 889. 90	9, 563. 35	30, 768. 94	21, 205. 59	9, 563. 35
California	39, 689. 32	8, 315. 69	26, 919. 16	4, 454. 47	39, 689. 32	35, 234. 85	4, 454. 47
Colorado	27, 581. 49	8, 315. 69	6, 132. 80	13, 133. 00	7, 421. 71	7, 421. 71	----------
Connecticut	20, 139. 85	8, 315. 69	7, 632. 92	4, 191. 24	20, 139. 85	15, 948. 61	4, 191. 24
Delaware	11, 390. 71	8, 315. 69	1, 370. 25	1, 704. 77	7, 747. 00	6, 697. 00	1, 050. 00
Dist. of Columbia	14, 574. 49	8, 315. 69	3, 483. 00	2, 775. 80	14, 522. 80	11, 747. 00	2, 775. 80
Florida	26, 324. 17	8, 315. 69	9, 179. 43	8, 829. 05	26, 324. 17	17, 495. 12	8, 829. 05
Georgia	59, 638. 63	8, 315. 69	22, 217. 08	29, 105. 86	59, 638. 63	30, 532. 77	29, 105. 86
Hawaii	16, 938. 05	8, 315. 69	3, 193. 70	5, 428. 66	8, 343. 33	8, 343. 33	----------
Idaho	15, 752. 38	8, 315. 69	3, 220. 50	4, 216. 19	15, 752. 38	11, 536. 19	4, 216. 19
Illinois	48, 880. 43	8, 315. 69	37, 872. 91	2, 691. 83	(4)	(4)	(4)
Indiana	30, 443. 80	8, 315. 69	17, 986. 76	4, 141. 35	20, 573. 19	19, 063. 06	1, 510. 13
Iowa	34, 967. 99	8, 513. 69	14, 590. 00	12, 062. 30	26, 224. 43	14, 162. 13	12, 062. 30
Kansas	37, 446. 37	8, 315. 69	11, 154. 07	17, 976. 61	25, 260. 83	19, 469. 60	5, 791. 23
Kentucky	36, 251. 16	8, 315. 69	20, 582. 61	7, 352. 86	28, 898. 30	28, 898. 30	----------
Louisiana	31, 485. 36	8, 315. 69	14, 775. 54	8, 394. 13	31, 485. 36	23, 091. 23	8, 394. 13
Maine	19, 782. 24	8, 315. 69	5, 415. 03	6, 051. 52	19, 496. 95	13, 445. 43	6, 051. 52
Maryland	19, 788. 52	8, 315. 69	9, 393. 84	2, 078. 99	19, 788. 52	17, 709. 53	2, 078. 99
Massachusetts	30, 246. 56	8, 315. 69	21, 930. 87	----------	28, 444. 22	28, 444. 22	----------
Michigan	39, 230. 74	8, 315. 69	28, 836. 06	2, 078. 99	37, 995. 54	35, 916. 55	2, 078. 99
Minnesota	24, 093. 83	8, 315. 69	15, 778. 14	----------	21, 732. 00	21, 732. 00	----------
Mississippi	51, 000. 44	8, 315. 69	16, 445. 40	26, 239. 35	51, 000. 44	24, 761. 09	26, 239. 35
Missouri	28, 651. 25	8, 315. 69	20, 335. 56	----------	20, 875. 00	20, 875. 00	----------
Montana	15, 892. 07	8, 315. 69	3, 418. 40	4, 157. 98	15, 338. 09	11, 734. 09	3, 604. 00
Nebraska	24, 559. 62	8, 315. 69	8, 619. 03	7, 624. 90	9, 400. 00	5, 541. 67	3, 858. 33
Nevada	24, 467. 35	8, 315. 69	492. 71	15, 658. 95	16, 428. 95	770. 00	15, 658. 95
New Hampshire	18, 919. 58	8, 315. 69	2, 703. 73	7, 900. 16	11, 975. 67	6, 313. 00	5, 662. 67
New Jersey	29, 523. 26	8, 315. 69	18, 739. 92	2, 467. 65	13, 566. 67	13, 566. 67	----------
New Mexico	28, 873. 41	8, 315. 69	4, 387. 34	16, 170. 38	28, 873. 41	12, 703. 03	16, 170. 38
New York	82, 904. 16	8, 315. 69	63, 776. 06	10, 812. 41	78, 579. 19	72, 091. 75	6, 487. 44
North Carolina	50, 121. 32	8, 315. 69	27, 385. 76	14, 419. 87	50, 121. 32	35, 701. 45	14, 419. 87
North Dakota	18, 927. 89	8, 315. 69	4, 998. 93	5, 613. 27	9, 724. 27	4, 111. 00	5, 613. 27
Ohio	47, 698. 96	8, 315. 69	34, 392. 69	4, 989. 58	22, 010. 00	19, 010. 00	3, 000. 00
Oklahoma	25, 869. 79	8, 315. 69	16, 252. 65	1, 301. 45	18, 176. 45	16, 875. 00	1, 301. 45
Oregon	20, 176. 80	8, 315. 69	4, 493. 17	7, 367. 94	(4)	(4)	(4)
Pennsylvania	73, 569. 81	8, 315. 69	55, 056. 70	10, 197. 42	63, 371. 66	63, 371. 66	----------
Rhode Island	11, 871. 53	8, 315. 69	3, 555. 84	----------	8, 396. 67	8, 396. 67	----------
South Carolina	38, 493. 57	8, 315. 69	15, 209. 15	14, 968. 73	34, 128. 66	23, 385. 03	10, 743. 63
South Dakota	16, 833. 50	8, 315. 69	4, 526. 15	3, 991. 66	16, 833. 50	12, 841. 84	3, 991. 66
Tennessee	35, 448. 49	8, 315. 69	18, 001. 88	9, 130. 92	35, 448. 49	26, 317. 57	9, 130. 92
Texas	70, 333. 82	8, 315. 69	40, 064. 00	21, 954. 13	42, 001. 66	38, 765. 06	3, 236. 60
Utah	17, 646. 91	8, 315. 69	4, 341. 64	4, 989. 58	10, 610. 50	7, 610. 50	3, 000. 00
Vermont	23, 387. 58	8, 315. 69	2, 265. 31	12, 806. 58	14, 250. 34	1, 942. 67	12, 307. 67
Virginia	34, 627. 34	8, 315. 69	17, 995. 69	8, 315. 96	34, 627. 34	26, 311. 38	8, 315. 96
Washington	23, 794. 12	8, 315. 69	7, 744. 59	7, 733. 84	23, 794. 12	16, 060. 28	7, 733. 84
West Virginia	27, 763. 34	8, 315. 69	14, 250. 18	5, 197. 47	27, 763. 34	22, 565. 87	5, 197. 47
Wisconsin	29, 316. 74	8, 315. 69	17, 667. 22	3, 333. 83	25, 982. 91	25, 982. 91	----------
Wyoming	12, 862. 97	8, 315. 69	1, 568. 50	2, 978. 78	9, 183. 78	6, 205. 00	2, 978. 78

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[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] In 37 States the operation of the plan was to start Feb. 1, and payment was made on the basis of the full 5-month period. In Minnesota the plan was to start Feb. 16; in Alaska, Arizona, New Hampshire, Rhode Island, and Texas, Mar. 1; and in Colorado, Delaware, Indiana, North Dakota, Ohio, and Utah, April 1.

[3] The amount of this fund allotted to each State with an approved plan remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

[4] Plan not approved.

Sources of Funds and Proposed Expenditures.

The Social Security Act provides that funds allotted to each State under section 502 (a) shall be paid to the State quarterly, in an amount equal to one-half of the total sum to be expended during the quarter for carrying out the State plan within the total amount available to the State.[3] Accordingly, it was necessary for each State to show in its budget State and local appropriations for maternal and child-health services sufficient to equal the amount of Federal funds requested from fund A. (See p. 6.) The budgets usually showed all State appropriations for maternal and child-health services and only enough appropriations by local health agencies to complete the matching of the Federal sums requested. The inclusion of local funds for matching Federal funds made the local maternal and child-health programs so financed a part of the Federal-State cooperative program, subject to the supervision of the State health agency.

The proposed expenditure of the funds requested by the State agency from fund B (see p. 6), for which matching was not required, was also included in the budget submitted.

The figures given on pages 21–22 are on a 6-month basis. The State health officers had their budgets for the last 6 months of the fiscal year 1936 in preparation before it was known that the first Federal appropriation for grants to the States would cover only the 5-month period, February 1 to June 30, 1936, and the 6-month figures were included in the State plans submitted. Adjustment to a 5-month basis was made in the total amount approved, and the Federal grant to each State was correspondingly adjusted.

The following list shows the sources of the funds for estimated expenditure for maternal and child-health services under title V, part 1, of the Social Security Act, as shown in the budgets which were a part of the State plans approved for the last 6 months of the fiscal year 1936 for 46 States, the District of Columbia, Hawaii, and Alaska.

Services and source of funds	*Estimated expenditure*	*Percent distribution*
Total	$3, 277, 032. 36	-----
State services	1, 890, 012. 82	100. 0
State sources	772, 288. 90	40. 9
Federal grants to States	1, 117, 723. 92	59. 1
Local services	1, 387, 019. 54	100. 0
Local sources	696, 198. 94	50. 2
State sources	248, 515. 60	17. 9
Federal grants to States	442, 305. 00	31. 9

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[3] Payments at the beginning of the fiscal year are based on estimated expenditures, and succeeding payments from quarter to quarter are adjusted in accordance with actual sums expended.

The fact that three-fifths of the funds for State services was to come from the Federal grants, as shown in these figures, suggests that appropriations for maternal and child-health services in some States were decidedly limited and that there was great necessity for expansion of such appropriations. The opportunity for future extension of services undoubtedly lies in the local communities, many of which still lack maternal and child-health services. If the States can increase their State appropriations, the increase will make possible the use of more of the Federal funds in the local areas, thereby providing for greater assistance in improving and extending local maternal and child-health services as called for by the Social Security Act.

The following list shows the types of expenditure from Federal, State, and local sources proposed by the State health officers in the State plans for the 6 months ended June 30, 1936.

Type of expenditure	*Proposed expenditure*	*Percent distribution*
All types	$3, 277, 032. 36	100. 0
Salaries and fees	2, 259, 244. 78	68. 9
State division directors and assistant directors	101, 913. 00	3. 1
Health officers (county or local largely)	180, 422. 85	5. 5
Physicians	309, 356. 33	9. 4
Public-health nurses	1, 248, 736. 67	38. 1
Dentists and dental hygienists	104, 163. 50	3. 2
Nutritionists	19, 300. 00	. 6
Health educators	23, 424. 59	. 7
Other professional service	53, 165. 52	1. 6
Clerical service	200, 354. 32	6. 1
Other	18, 408. 00	. 6
Travel	506, 321. 54	15. 5
Supplies	179, 625. 56	5. 5
Equipment	115, 801. 09	3. 5
Communication	36, 374. 82	1. 1
Printing	38, 443. 83	1. 2
Publications for distribution	51, 003. 00	1. 6
Rent	9, 210. 33	. 3
Other	81, 007. 41	2. 5

Such a summary of the budgets in the annual State plans will show each year for what purposes the State health officers consider that the funds can be used to best advantage. The series of annual summaries will show the trend in the distribution of the funds available between local and State services and the trend in the use of physicians, nurses, dentists, nutritionists, and others in the program, as well as in expenditures for purposes other than personal service. Reports of actual expenditures will reveal how the plans are modified in operation.

State Divisions of Maternal and Child Health.

Progress made in the establishment of divisions of maternal and child health in the State health departments and in the appointment of qualified physicians to the staffs of these divisions may be used as an initial standard in evaluating progress.

In June 1934, when the President's Committee on Economic Security was beginning its work, there were 31 States with a division of maternal and child health in the State department of health, but in only 22 of these—less than half of the States—was the director a physician on a full-time basis.

Each of the 1936 plans approved for 46 States, the District of Columbia, and 2 Territories, provided for a bureau or division of maternal and child health and for a physician as its director. All but four of the directors had been appointed by June 30, 1936. The great majority of the directors are either pediatricians or obstetricians, and in a number of cases they have also been trained in public-health administration.

These two features of the plans insure administration of the maternal and child-health program in the States as a major health service under full medical direction and supervision, so that it will command the confidence of the medical profession and of the public.

Forty-four directors of divisions of maternal and child health attended the June 1936 conference called by the Children's Bureau. (See p. 6.) The conference gave an opportunity for general and individual consultation and exchange of experience on methods of administration and on maternal and child-health services being rendered or to be rendered in the States.

Based on the work of these divisions and on the extension of service in the States reports of progress for the period ended June 30, 1936, were sent to the Children's Bureau by the State health officers. Many of the statements made in the pages that follow were drawn from these reports.

Services of Other Divisions of State Health Departments.

An important part of maternal and child-health services is public-health nursing. Usually the local public-health nurse organizes and conducts a major portion of the service to mothers and children. In some States the nursing service of the State department of health is part of the division of maternal and child health. In others a generalized public-health-nursing service is set up as a separate bureau or division serving all divisions of the department. In the latter case the director of public-health nursing advises the director of maternal and child health on the nursing phases of the program. Public-health nurses who have specialized in maternal and child health are frequently employed so that they will be available to give advisory or supervisory service to nurses who do maternal and child-health work as part of a generalized program.

In several State departments of health there is a bureau or division of local health work. Usually the major function of such a division is to aid counties or other local subdivisions in establishing and developing county or local health units or departments. The relation of the specialized divisions to such a division of local health work is cooperative. The maternal and child-health division, for example, supplies the advisory and supervisory service for the maternal and child-health activities in the local health units that are established.

Other divisions of the State health department also perform important services related to child health. Statistics of births, infant deaths, and maternal deaths are fundamental in planning the maternal and child-health program. The control of contagious diseases involves children, and the most effective preventive work for certain diseases is the immunization of children. Much of the bacteriological work is done on behalf of children. The protection of the milk supply benefits children as well as adults. A large part of the educational publications distributed by the State health department are for the benefit of the health of mothers and children.

Though these indirect services are fundamental to the health of mothers and children, as are all basic health procedures, the funds for maternal and child-health services were designated by the State health officers very largely for direct services for mothers and children by physicians, public-health nurses, and others.

Qualifications of State and Local Personnel.

To aid the States in the selection of personnel the State and Territorial health officers, meeting in Washington in 1935, adopted a report suggesting qualifications which they considered adequate for the medical director of a State division of maternal and child health, and for nursing personnel. For the special staff in nutrition, mouth hygiene, health education, and mental hygiene, the report recommended using the qualifications recognized as adequate by the respective national professional organizations.

Some of the State plans provided for scholarships for new appointees who had basic qualifications for public-health work but who needed special training for maternal and child-health service. Many States provided for in-service training for State and local personnel through conferences and institutes and through observation or participation in demonstration maternal and child-health services.

Since the program is entirely dependent for success on acceptance by the public of the services offered, it is obvious that the personnel giving the service must be sufficiently well qualified to command the continuing confidence of the groups to be served.

Types of State and Local Service.

The major portion of each State plan was concerned with providing mothers and children with service in the fields of maternal health, infant health, preschool health, and the health of the school child.

Maternal-health service consists (1) in reaching the expectant mother as early as possible during pregnancy to make sure that she is under continuous medical supervision either by her private physician or at a prenatal clinic, (2) in providing her with instructions as to her own care through the advice of a physician, through publications, and through a nurse's home visits, and (3) in making sure that she receives competent medical and nursing care at the time of delivery and supervision during the postpartum period.

Infant-health service consists in instruction of the mother through the periodic examination of the baby by a physician, with directions to the mother as to his feeding and care; through nurses' home visits to instruct the mother; and through publications. The examination of the baby by the physician is done either at a well-baby conference or, in some cases, by the family physician, when plans for this type of service have been worked out by the health department in cooperation with local physicians.

Preschool-health service similarly includes the instruction of the mother through publications and nurses' visits to the home, and the examination of the child (at less frequent intervals than in infancy) by the family physician or by the physician at the child-health conference, with directions to the mother as to his care and habit training. Vaccination against smallpox and immunization against diphtheria are included at this time or in the earlier period. Special effort is made to have remediable defects corrected before the child enters school. Dental supervision and the training of the child in the care of the teeth become increasingly important during this period.

School-health service includes the periodic medical examination of the child, preferably in the presence of one or both parents; follow-up in an effort to have defects corrected; protection against contagious diseases; and the education of the child in the care of his own health and in his responsibility in connection with the health of the family and the community. Dental and nutritional supervision and instruction are important throughout the period of growth. In some States, as part of the school-health service, special health examinations are given to children applying for employment certificates.

The State plans for maternal and child-health services all provided for the services outlined, with varying emphasis according to the stage of previous development, the special health needs in the State, the funds available, and the division of responsibility between the State health department and other agencies.

Because sufficient funds were not available to provide maternal and child-health services in all communities and because the Social Security Act called for extension of services especially in rural areas, first attention in the State plans was given to such areas. Where there was an organized county or district health unit, with a health officer and a public-health nurse on the staff, the maternal and child-health services were strengthened by the addition of one or more nurses or by the provision of more health supervisory service by physicians through part-time service at prenatal and well-child conferences. Where such units were not yet organized, the expansion of service was frequently started with the appointment of a county public-health nurse, paid in part or in whole by the county, with medical and nursing supervision provided by the State bureau of maternal and child health and the division of public-health nursing, and with local medical service on a part-time basis for prenatal and child-health conferences. The Federal funds available made it possible in many States for the State health agency to provide funds in selected areas for such local services sufficient to pay part, or in some cases all, of the salaries of one or more employees.

Under the new program each State plan, so far as funds permitted, provided for the establishment or expansion of the maternal and child-health division in the State department of health. Medical supervision of the program was provided by the division director and by one or more obstetricians or pediatricians employed either as staff members or as consultants on a part-time basis. Nursing supervision was provided either by the maternal and child-health division or by the public-health-nursing division; in some States specialized nurse supervisors of maternal and child-health work were added to the staff. Dentists, dental hygienists, nutritionists, and health educators were employed in some States.

The major functions of divisions of maternal and child health, as they appeared in the State plans, included aid in the organization of local child-health services, improvement of such services through consultation and supervision, provision for training State and local public-health personnel in the conduct of such services, plans for the postgraduate instruction of physicians and nurses in private practice, and the conduct of a health-education program through distribution of publications and by other means. From February to June 1936 the principal advances made were in the formulation of State plans, in the recruiting of State staff, and in the consultation of various official, professional, and lay groups. The progress reports for this period, however, also showed substantial advances in improving and extending local maternal and child-health services.

The State reports that gave information by districts, counties, or towns showed that new work had been started in 20 health districts, 204 counties, and 73 towns, and that existing services had been expanded in 26 districts, 215 counties, and 50 towns. Preliminary work to start or expand services was reported in many more areas.

Educational Programs in State Plans.

The major objective of the whole program, furthered by a large part of the State and local activities, is the education of the mother in the care of herself and her children. The education of the father as to his responsibility for family health is also important in order that he may intelligently cooperate with his wife in establishing family health practices. He also should appreciate the need of obtaining adequate medical care and supervision for every member of the family. Insofar as high standards of care of the health of mother and children are absorbed into family custom and practice fundamental and lasting protection is given to the health of the family and of the community.

Preparation for working toward this major objective was made in the State plans through provision for the postgraduate training of professional groups, for the in-service training of health workers, and for health-education service for the schools and for the public.

Many of the plans made provision for staff training for physicians and nurses through conferences or institutes, through participation in county demonstration services, and, to some extent, through scholarships for advanced training in maternal and child health at schools of public-health administration or schools of public-health nursing. Such training will be of continuing importance in improving the quality of service rendered by State and local employees.

Educational services for local physicians were provided for in a majority of the State plans through institutes and postgraduate courses to keep physicians in touch with the latest medical developments in obstetrics and pediatrics. (See p. 78.)

The State plans, assuming that the child receives his first health education at home, provided, with varying emphasis, for the education of children in school, first in habits of personal hygiene and, as they grow older, with regard to their future responsibilities for maternal and child care. In some States the health education of children is entirely a school function, with the health department serving only in an advisory capacity. The majority of the States in their 1936 plans contemplated programs for the health of the school child but postponed development of such programs to a later period. The Indiana, Iowa, Kentucky, Massachusetts, Ohio, and Virginia plans for the health education of school children were particularly extensive.

Several States are employing as health educators physicians with recognized teaching ability or other individuals especially trained in health education. These health educators act in liaison with State departments of public instruction in outlining the content of school-health programs, in conducting health institutes for teachers in normal schools, and in integrating generally the health teaching of the school with the activities of the State health department. Obviously the success of such educational programs will depend on the professional ability, personality, and adaptability of the physicians and other professional workers appointed.

The Indiana plan for 1936 included a health-education program worked out with special care. A physician experienced in health education was placed on the staff of the bureau of maternal and child health of the State health department to cooperate with the State department of public instruction. His first work was to arrange for and supervise talks on child health and maternal welfare, to be given at State colleges, normal schools, and high schools, for students who were to become teachers. Activities proposed in the Indiana plan included expanding such services in the high schools and extending them into the grade schools, supervising material for textbooks, and cooperating with such organizations as parent-teacher associations. The chief emphasis was to be placed at first on the dissemination of health knowledge to teachers.

Demonstration Services.

The Social Security Act prescribes that each State plan shall provide for the development of demonstration services in needy areas and among groups in special need. This requirement made it possible for each State health agency to use a part of its Federal funds to develop one or more demonstrations under State direction, providing, for example, either a well-rounded maternal and child-health service in a selected area or a project designed to meet the special need of a particular area or group. The demonstration services so undertaken serve as testing grounds for methods and procedures in attacking maternal and child-health problems. As the methods and the results attained are studied and reported they will be of value in guiding the program in other areas within the State and in other States. Twenty-four demonstration services were reported to be under way on June 30, 1936, or ready to start soon after. Others were in the preliminary stages of development.

The demonstration services started can be classified roughly as follows:

County or local maternal and child-health demonstrations in areas with high maternal or infant mortality—Alabama, Alaska, Georgia, Missouri, Ohio, Oklahoma, South Carolina, South Dakota, and Tennessee.

County training centers for public-health personnel—Arkansas and West Virginia.

Maternal-care demonstrations—Connecticut, Iowa, Maine, Maryland, Michigan, New Hampshire, New Jersey, Tennessee, Washington, and Wisconsin.

Special services—Delaware, nutrition demonstration in Kent County; Indiana, dental demonstration; Rhode Island, dental-hygiene demonstration in Bristol County.

The following descriptions of demonstrations under way on June 30, 1936, illustrate the types of work undertaken:

Alabama expanded the maternal and child-health services in Jefferson County to make such services available in rural areas and more accessible in needy city areas. By June 30, 5 new health centers were in operation (12 were planned). Mothers visit the centers for prenatal and postnatal examinations and advice given by a local practicing physician with a nurse in attendance. A consulting obstetrician attends from time to time to instruct attending physicians at the same time that service is being given to the patients. Similarly, children are examined by a local physician, and a pediatrician attends periodically to instruct the physicians as service is given the mothers and children. Three centers have dentists in attendance to make dental examinations and to do temporary or emergency dental work. The dentist and the nurse give instruction in oral hygiene. Eight nurses and a social worker were added to the staff during the first 5-month period. Mothers and children from families in the low-income group receive the services described.

Iowa has undertaken a maternal-care program in Washington County with the cooperation of all the local physicians. Two afternoons a week physicians, who are paid by the State health department, give without cost to the family prenatal care and supervision in their private offices to any expectant mother residing in the county who is otherwise unable for economic or other reasons to get such care. The mother receives a complete obstetric examination, including a Wassermann test for syphilis; regular subsequent check-ups, including blood-pressure readings and urinalyses, during the period of pregnancy; and a final postpartum examination. A nurse is assigned to make instructional home visits to the mothers thus cared for and to organize and conduct classes in maternal hygiene. County nurses assist private physicians with the delivery of indigent mothers in the home and give postpartum nursing care to those mothers. Sterile obstetric kits are supplied to physicians for use in connection with home deliveries.

In *Maine* an area including several towns was chosen in which to carry on a complete, intensive demonstration of maternity-nursing service, including prenatal, natal, and postnatal care. In this area about 200 births occur a year. Many of the families have small incomes. Medical facilities and hospitals are adequate. Three public-health nurses—one a supervisor—were to be employed. Nursing assistance at the time of delivery was to be given on the request of the attending physician to any woman who had been under his supervision during the prenatal period. By June 30, 1936, the nursing supervisor had been engaged, report forms and instructions for nurses had been prepared, and contact had been made with the medical societies and with individual physicians to explain the demonstration. Field service was to start in July.

Maryland has placed two nurse-midwives in Wicomico and Charles Counties, where 50 percent of the births are attended by midwives. The nurses, who have obstetric training, are to give delivery nursing service and raise standards of midwifery in cooperation with physicians.

In *Oklahoma* a five-county demonstration is being conducted by the Oklahoma State Department of Public Health, the United States Public Health Service, the United States Office of Indian Affairs, and the United States Children's Bureau. The counties selected (Cherokee, Adair, Delaware, Mayes, and Sequoyah) have an Indian population of 23 percent; the incidence of typhoid fever, diphtheria, tuberculosis, and malaria was high; maternal and infant mortality rates were high; and 35 percent of the people were on relief. The maternal and child-health staff includes a pediatrician as director, a supervisor of nurses, and five field nurses who do maternal and child-health work as part of a generalized program.

As a result of a recent survey to inquire into the causes of high infant mortality in Memphis,[4] *Tennessee* selected for one demonstration service the carrying out of the recommendations of the survey. With State aid the staff of the Memphis Health Department was strengthened and its maternal and child-hygiene services were expanded and improved. The city government appropriated funds for a maternity center to be located in an outlying section, from which the general hospital clinics draw most of their patients.

On June 7, 1936, *Washington* began a maternal-care demonstration in an area comprising approximately 150 square miles (centering in Everett, Snohomish County) after consultation with the county medical society and with physicians, nurses, and lay groups. Two-hour classes every 2 weeks are provided for expectant mothers within the area and for all women who care to come. These classes are held with an obstetrician and a nurse alternately as instructors. Nutritionists and dentists assist in the teaching program. Home visits by a nurse to give instruction and advice are made in prenatal cases within the area. Registered nurses in private practice are also trained in the demonstration area. They are given a 3-month course in home-delivery service for which they receive a certificate. Public-health nurses are given training in the same course, with the expectation that they will set up similar courses for nurses in their own localities.

West Virginia has established a demonstration service in Fayette, Raleigh, and Wyoming Counties, with headquarters at the county seat of Raleigh County. Quarters and some furnishings were provided by the county board of education and the county court. The unit is being used as a training center where health officers, public-health nurses, and sanitary engineers may get field experience. Its staff includes a physician who is the director, a chief nurse, and a sanitary engineer, who supervise the corresponding officials in the three counties. Classes are conducted covering all phases of maternal and child hygiene, as well as other phases of public-health work. Demonstration clinics are held to show how the various clinics and conferences should be conducted. Supervision and instruction of midwives are also part of the training program.

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[4] See Infant Mortality in Memphis (U. S. Children's Bureau Publication No. 233, Washington, 1936).

Efforts to Protect Maternal Health.

The unnecessarily high maternal death rate in the United States has caused health officials and medical societies to direct their attention toward means of safeguarding the lives and health of mothers. The 1936 State plans for maternal and child-health services clearly reflected this emphasis. Postgraduate courses in obstetrics for physicians and the further promotion of prenatal conferences were the two outstanding methods of attack. Ten States had maternal-care demonstrations under way by July 1, 1936—Connecticut, Iowa, Maine, Maryland, Michigan, New Hampshire, New Jersey, Tennessee, Washington, and Wisconsin. Several others had done preliminary work on such demonstrations. The demonstrations varied in type, including prenatal nursing service, delivery nursing service, maternal-hygiene service organized by nurse-midwives who give training to midwives, and maternal-care training programs combining the giving of service with the training of physicians and nurses for public-health work and for better service to the women in their communities.

Midwives attend a large proportion of the births in certain States, and many are inadequately trained or entirely untrained. More than a third of the States included in their 1936 State plans supervision and training of midwives. In many States deliveries are made without medical attention because the doctors are far away or too few to serve the population, because the families cannot afford medical service, or because family tradition does not call for the services of a physician at childbirth. From the public standpoint the problem at present calls for careful licensing and supervision of midwives.

Usually instruction is given midwives in classes conducted by the local public-health nurse. In some States the State advisory nurse supervises midwives in counties without public-health organization. In Kentucky two public-health nurses of long experience in maternal and child-health work took courses in midwifery for the purpose of returning to conduct a demonstration in bedside training of rural midwives.

Other States have appointed as State midwife supervisors nurse-midwives trained at the school for midwives, who are equipped to help teach midwives the fundamentals of good practice.

Medical Participation.

Every State plan showed cooperation with the medical profession. Frequently the State medical society was consulted and gave advice on the formulation of the State plan. Thirty-five States reported the inclusion of a representative of the State medical society on the State advisory committee for the maternal and child-health programs. In several States a representative of the State school of medicine was also on the committee. Seven additional States reported medical representation on various special advisory committees. Pediatricians and obstetricians, as individuals or as representatives of State societies, were frequently included on the general advisory committee or on technical advisory committees. Committees on maternal welfare of State and county medical societies were often mentioned as participants in planning the activities to be undertaken.

Local physicians are employed in many of the States for the conduct of prenatal, postnatal, infant, and preschool clinics and conferences. In a few States where the physical examination of school children is under the supervision of the State health agency, the State plan provides for the employment of local physicians for this purpose. Although the funds for local medical service are limited, most States have budgeted for the payment of local physicians.

The new program affords opportunity for postgraduate instruction in pediatrics and obstetrics for physicians in private practice. The opportunity has been eagerly welcomed by medical groups. The lecture courses described in State plans are given in cooperation with State and local medical societies.

Thirty States in their 1936 plans budgeted sums of money to be used for such postgraduate education of physicians, and 15 actually had such programs in progress by June 30. Because of the short time between the receipt of Federal funds and the expiration of the fiscal year 1936, many of the States deferred any postgraduate education until a later date.[5] Two of the early reports received gave the following information:

Kansas reported a "refresher" course for physicians in obstetrics and pediatrics, starting June 22, covering 31 counties in the western part of the State. Six towns were visited weekly for 4 consecutive weeks. Of the 199 licensed physicians in the area covered 119 attended; in 6 counties every practicing physician registered.

In seven towns in North Carolina, in May and June 1936, 1-week lecture courses in obstetrics were held. Each course consisted of five afternoon lectures. Motion-picture films were used for illustrative purposes. About 600 physicians from about 275 places in the

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[5] Forty-one States carried on such programs during the fiscal year ended June 30. 1937.

State attended one or more of the lectures. The attendance included one-third of the active general practitioners who include obstetrics in their practice.

On June 30, 1936, four States had on their staffs full-time obstetricians or pediatricians carrying out State-wide postgraduate teaching and consultation. This type of postgraduate teaching has proved especially valuable, and more States were planning to make such appointments during the fiscal year 1937.

The Local Public-Health Nurse.

More than one-third of the Federal, State, and local funds for maternal and child health budgeted in State plans for the fiscal year 1936 were designated for the employment of public-health nurses in local areas. These local public-health nurses, functioning in organized district or county health units under the direction of the local health officer and in other areas under the immediate direction of the State department of health, carry an important share of the responsibility for the local health program.

The public-health nurse, through her various nursing services in the home, gains the confidence of the family, showing them the importance of health supervision of mothers and children by their own physicians or through prenatal and child-health conferences. The public-health nurse helps arrange for such conferences, assists the physician with his examination of mothers and children, and helps interpret his instructions to them. She also teaches individuals and groups of mothers verbally and by demonstration at the time of the health conference.

Through visits to the families in their own homes she teaches by demonstration and through actual nursing care the application of scientific knowledge and procedure to everyday living, adapting her teaching to the conditions in various homes. She frequently extends her public-health-nursing services to the school, so as to give continuity to the services throughout the school period. Here she assists the physician with health examinations and with measures for controlling communicable disease. She helps teachers as well as parents to understand the health needs of children and to know about the health services that the community makes available.

Public-health-nursing services to individuals and families are supplemented and reinforced through group educational activities such as classes and conferences, as well as through the distribution and interpretation of health publications.

The State advisory or supervisory nurse plans the nursing program with the director of the State division of maternal and child health and assists the local nursing staff to establish and maintain a generalized nursing service in which the maternal and child-health activities are given sufficient emphasis to meet the health needs of the families in the community.

The State plans and progress reports for the fiscal year 1936 showed provision by various means for an increase in the number of local public-health nurses. Where the health services are centrally administered, public-health nurses were employed directly by the State health department for work in local areas. In some States a sum to pay part of the nurse's salary was offered to the county or district on condition that the appointee should meet standard qualifications set by the State. In other cases State nurses were lent to the counties with the expectation that the county would later appropriate funds for employing nurses.

State progress reports showed that the usual heavy service demands on the rural public-health nurses were in some cases appreciably reduced by the augmented personnel made possible by Federal maternal and child-health funds. Where more nurses were employed a better quality of service to mothers and children was made possible, and the nurses were able to develop added activities such as group instruction at prenatal clinics and well-baby conferences. However, in many States the added nursing personnel was employed in rural areas that previously had had no public-health-nursing service. It still remains true, therefore, that many a county nurse is serving too large a district and population to be able to give adequate service.

Many State plans made provision for the in-service training of public-health nurses as a means of attaining higher standards of maternal and child-health nursing service. The progress reports showed that stipends had been provided to enable a considerable number of nurses to attend special courses in maternal and child-health nursing or public-health nursing. State advisory nurses and educational supervisors plan systematic staff-education programs, including institutes and meetings, as well as manuals of the objectives and procedures in the nursing service.

The following illustrations from the progress reports show the various ways in which the States are extending and improving the nursing service in the maternal and child-health program:

In Arkansas, Georgia, Iowa, Massachusetts, Minnesota, New Mexico, North Carolina, South Carolina, and Tennessee, State supervisory nurses have been added to the staff. South Carolina assigned four supervisory nurses for the organizing of prenatal and well-baby clinics throughout the State. Georgia, Louisiana, Maryland, and Oklahoma have increased the supervisory service directed toward improving the quality of midwifery.

The State supervisory nurses in Georgia and Mississippi are stimulating the promotion of full-time public-health-nursing services in areas having no health service. In Wisconsin 10 counties established public-health-nursing services during the first half of 1936 under a 1935 State law authorizing a grant of $1,000 to each county employing a public-health nurse. Michigan reported the loan of State nursing staff to seven localities.

Minnesota, North Carolina, and West Virginia reported the establishment of rural training centers where new staff nurses are to receive intensively supervised field practice.

Dental-Hygiene Service.

State and local dental societies are actively participating in the program. They are represented on State advisory committees in most of the States.

Many State plans for maternal and child-health services include provision for dentists and dental hygienists. In many States full-time dentists, appointed upon recommendation of the State dental society, act as coordinators of dental education in the State and assist county dental societies in the development of dental clinics for educational and corrective services.

Thirty States included dental-hygiene programs in their 1936 State plans. Some of the dentists and dental hygienists employed for this work were in the division of maternal and child health and others were in the dental-hygiene division. In Kansas a unified program had been adopted in 23 counties by June 30, involving the cooperation of dentists, teachers, and public-health nurses in a program including examinations, teaching, and follow-up. In Minnesota as a demonstration service the State health department started a study, in cooperation with the university medical school and the Mayo Foundation, on the relation of fluorine in water to dental caries and dental defects. North Carolina, through its oral-hygiene division, conducts a State-wide dental service for school children and planned to add dentists to the staff for work with expectant mothers and preschool children at health centers. In Rhode Island under the direction of a part-time dentist on the State staff a dental-hygiene demonstration was undertaken in Bristol County, including dental clinical work for expectant mothers and preschool children and lectures and demonstrations of prophylaxis for children and adults.

The chief demonstration service started in Indiana was a dental service for children in Owen and Greene Counties. The demonstration was to start July 30 after preliminary organization, which included placing a county health nurse in the area, obtaining the cooperation of local dentists and welfare groups, and ordering dental equipment and supplies. A mobile dental office was constructed for the purpose. The program is in charge of dental officers in the State maternal and child-health bureau, one a field director to be in charge of the educational work and the other a dental operator to take charge of the mobile dental office. The mobile dental unit was to be equipped entirely for children's dentistry. It was proposed that dental attention be given to children in families unable to pay for it, as a means of improving the general health of the children of the community selected. Before the appearance of the mobile unit in any community, an educational program was to be carried on in the public schools, bringing to the attention of all school children the importance and necessity of adequate dental care.

Nutrition Programs.

Of the 49 States for which plans had been approved before July 1, 1936, 9 had made provision in the budget for a staff nutritionist; 4 of these had appointed one or more workers. Three additional States reported plans for securing the full-time or part-time services of a nutritionist connected with the agricultural-extension service or some other State agency. Nutritionists are participating in educational plans for training workers who will come into contact with mothers and children; that is, public-health nurses, dental hygienists, and health-education workers. They also share in the planning and conduct of demonstration services. Their activities include: (1) Collecting and preparing literature and exhibits, (2) consulting with nurses and other workers on typical or problem cases, (3) conducting study groups or demonstration classes for staff workers and student teachers, (4) enlisting the support and effective cooperation of local agencies dealing with nutrition and child health, (5) organizing and supervising classes for mothers, and (6) teaching nutrition to mothers and children at prenatal and well-child conferences.

The 1936 plan for Massachusetts, where nutrition service has been offered in the department of public health for more than 10 years, stated:

> We have used the nutritionists in our department to supplement the work done by our physicians and nurses, and we are convinced that there is a definite place in a public-health program for such service, either on a State-wide basis or a local basis. There is a particular need in the well-child conference * * * and in the community as a whole to give service not only to organizations but to individuals.

Emphasis on Work in Rural Areas.

The Social Security Act calls for the improvement of maternal and child-health services especially in rural areas. This provision was made in recognition of the fact that urban areas on the whole have been better served than rural areas.

In the 1936 plans (except that of the District of Columbia—an urban region) the State health officers directed their attention first to the provision of maternal and child-health services in rural districts. So far as possible the expanded service is financed, at least in part, by the county or other local subdivision. In cases where the State planned to start local service with workers to be paid from State funds, the State health officers stated their intention of encouraging the assumption of financial responsibility by the local subdivision.

Increasing allocations of State or local funds to maternal and child-health services in local areas will be needed if the State health officers are to be able to show each year extension and improvement of local maternal and child-health services when they request Federal grants.

Public Understanding.

The maternal and child-health program is dependent on public understanding for its acceptance, support, and expansion.

The program must be responsive to the needs and the desires of parents and particularly of mothers who come for instruction and accept and practice what they learn. If the best results are to be obtained, the initial stages of the program in any community should be planned with representatives of the groups to be served, and the plans so made should be widely explained in the community. Expansion of the local program to meet fully the needs of the community will come as a result of widespread understanding of the work being done.

As one means of promoting such public understanding the State health officers have included on the advisory committees for maternal and child-health services representatives of citizens' groups concerned with maternal and child welfare. As reported on June 30, 1936, State parent-teacher associations, State federations of women's clubs, and State departments of the American Legion were the organizations most commonly represented on State advisory committees. Other organizations included were the American Association of University Women, the League of Women Voters, the Federation of Business and Professional Women's Clubs, Rotarians, Kiwanians, Lions, and many others. In two States the Chamber of Commerce and in one the State Federation of Labor was represented, and five States had representatives of men's or women's farm organizations on such committees.

Georgia and Washington, as well as other States, are using such a method to promote local understanding of the program. County public-health councils or advisory committees are appointed for this purpose. In Minnesota, under a State law, county advisory nursing committees are appointed to work with the county public-health nurse.

Current Statistics and Special Studies.

Maternal and child-health programs in operation in all the States make possible the gathering of current statistics on health services rendered to mothers and children and special studies of service needed and of administrative procedure developed to meet State and local needs.

In April 1936 the conference of the State and Territorial health officers approved a report of its committee on records and reports presenting a plan for the tabulation of health-department services, and recommended the use of this plan as a basis for State reports of activities to be sent to the Children's Bureau and to the United States Public Health Service. The plan was accepted by the Children's Bureau as the basis for reports of maternal and child-health services.

The State health agencies were asked to begin July 1, 1936, the collection of data for quarterly reports on maternal and child-health services administered directly by the State health agency and those under local administration in counties or districts in which the local program is financed in whole or in part from Federal grants under title V, part 1, of the Social Security Act. In order that information might be available on the total volume of maternal and child-health services in every State, each State agency was requested to forward as a supplementary report available data on other maternal and child-health services rendered under public or private auspices. The quarterly report on maternal and child-health activities provides for entry of detail on medical, nursing, dental, and other services in the fields of maternal, infant, preschool, and school hygiene.

The Children's Bureau is directed by the Social Security Act to make studies and investigations to promote the efficient administration of this part of the act. Reports on such studies, together with similar reports made by State agencies, will make possible an exchange of experience between the States on methods of discovering and meeting the health needs of mothers and children.

Problems and Objectives.

During the 5-month period ended June 30, 1936, the State health agencies formulated and started operation under plans for the maternal and child-health services made possible by Federal grants to the States under the Social Security Act. State staffs, including pediatricians, obstetricians, public-health nurses, nutritionists, dentists, and health educators were assembled. General and technical advisory committees were appointed to assist State and local staffs in rendering health service to mothers and children.

Any evaluation of the program from the results obtained by June 30, 1936, would be premature. However, the spirit of cooperation shown by the State health officers, their eagerness to find and appoint qualified personnel, and the response of professional and lay groups has already justified belief in the far-reaching and lasting value of the services to be rendered to mothers and children.

The first full year of operation under the new program, beginning July 1, 1936, offered to each State health department and its division of maternal and child health the opportunity to strengthen the State advisory and supervisory service to local health agencies and to develop a State-wide educational program for public-health workers, for professional groups, and for mothers and children.

It is apparent that the problem in local communities is twofold. Where a program is under way the problem is how to reach more mothers and children and how to provide more complete and adequate service. For the community that has no local maternal and child-health service, the problem is how to get a start.

Although a great number of public officials, physicians, dentists, nurses, and representatives of health and social agencies and of citizens' organizations participated in the formulation and launching of the program in each State, nevertheless the program for some time to come will be too new to be well understood throughout the State. It needs careful and continuous presentation to the groups directly concerned and to the general public both as a State-wide program and as a program to meet local community needs. The discussion involved in this process should help to keep the program in each State sound in its objectives and methods of procedure, should obtain for it cooperative services, and should insure its steady development.

The new demonstration services initiated under the State plans will be subject to observation as they develop. These special projects, together with other experience in rendering maternal and child-health services, should reveal the extent and nature of the need for services and the successful methods of procedure in providing for such need. Particularly in the fields of maternal care, protection of the newborn child, nutrition, dental hygiene, the hygiene of the school child, and health education, the work is in the experimental stage. What should be done for mothers and children in these fields and how it should be done will be under continuous review.

The dissemination of information on the scientific aspects of maternal and child health and on administrative procedures will be developed increasingly by the Children's Bureau through conferences of technical and administrative groups, reports on studies of administrative practices, and staff consultation service to the States.

SERVICES FOR CRIPPLED CHILDREN [1]

Part 2 of title V of the Social Security Act authorizes an annual appropriation of $2,850,000 for grants to the States to extend and improve (especially in rural areas and in areas suffering from severe economic distress) services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling.

The first appropriation for grants to the States for these purposes was $1,187,000, for the period February 1 to June 30, 1936.

Children's Bureau Administrative Service.

The Crippled Children's Division of the Children's Bureau, with a physician as director, was placed in immediate charge of the administration of this part of the Social Security Act.

The Crippled Children's Division maintains close working relationships with the Maternal and Child Health Division, the Child Welfare Division, and the Social Service Division of the Children's Bureau; the United States Public Health Service; the Vocational Rehabilitation Service of the Office of Education and the Office of Indian Affairs, both in the United States Department of the Interior; and the American Red Cross.

The regional medical consultants of the Children's Bureau give consultation service to State agencies on the preparation of State plans and budgets for services for crippled children and on the development of programs. At first the consultants were asked to explain the terms of the part of the Social Security Act relating to crippled children. In several States aid was asked in formulating a new State program, and in others, in planning for the extension of an existing program. Among the subjects that State officials have discussed with the consultants are the organization of the State agency, procedures for locating crippled children, arrangements for diagnosis and for surgical and hospital care and for aftercare, provision for cooperative relationships, and the budgeting of funds available to cover the services planned. Frequently the consultants are asked to meet with advisory committees and with other groups whose understanding of the State plan is essential and to attend conferences called to arrange for cooperative services by various State agencies. They are also asked to furnish information as to how other States are dealing with various phases of service. By June 30, 1936, each of the States (not including Alaska and Hawaii) had been visited at least once by the medical consultants.

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[1] The information in this section is for the fiscal year 1936 (5 months Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

The regional nursing consultants confer with the State agencies regarding problems of nursing services associated with services for crippled children, including the locating of crippled children, the conducting of diagnostic and treatment clinics, and the provision of aftercare services by public-health nurses and orthopedic nurses. Eleven States had been visited by the nursing consultants by June 30, 1936.

The consultant orthopedic surgeon, by June 30, had visited Maryland, Pennsylvania, Virginia, North Carolina, South Carolina, and Georgia to confer with the State agencies on technical problems and on professional relationships.

Specialized consultation service to the State agencies was to be given by medical social workers in the fiscal year 1937.

A brief report on progress for the fiscal year 1936 was requested of the State agencies. Plans were made for more complete reports of activities under the State plans for the fiscal year 1937, to be sent in on forms provided by the Children's Bureau. The statistical consultant on the Bureau staff gives advice to the State agencies with regard to records and reports. Using these reports and other information received from the States, the Children's Bureau is able to serve the States as a clearinghouse for experience.

Advisory Service.

At its first meeting, held December 16 and 17, 1935, the advisory committee on services for crippled children considered various phases of the program and made recommendations looking toward its satisfactory development. Recognition was given to the principle that qualified personnel is essential for the efficient operation of State programs. Attention was drawn to the assistance that might be rendered by national organizations in the formulation of acceptable standards for professional personnel in their respective fields. Plans were made to work out continuing programs of professional education and to encourage the progressive training of personnel. Much stress was laid on the importance of the selection of hospitals in accordance with standards that would safeguard the quality of care. It was the consensus of opinion that physicians should be remunerated for services on the basis of policies to be established by the State agency in conjunction with State and local medical societies and the Children's Bureau.

It was suggested that during the initial stages of the program the various State definitions of a crippled child should be accepted pending further study and possible adjustments. Because of the many problems presented by children with cerebral palsy, it was recommended that special consideration be given to projects designed to care for this group of children. Emphasis was placed on the importance of the cooperation of the groups specified in the law. Attention was drawn to the valuable assistance in program planning to be obtained through the use of advisory committees with professional representation from the various fields of medicine, nursing, physical therapy, and social work.

The State and Territorial health officers (Apr. 16, 1936) adopted a committee report that included recommendations relating to the procedure to be followed when the State health department administers services for crippled children. The report also recommended that in the States where the health department does not administer these services it should be prepared to advise the administrative agency on the points covered in the report. The major recommendations were as follows:

That the program should be directed by a physician, preferably one experienced in the care of crippled children.

That a separate division or bureau under qualified personnel should be established.

That a general advisory committee and technical advisory committees on medical, surgical, and hospital procedures should be appointed.

Other recommendations related to the promotion of a uniform record system; an educational program for personnel; participation of local health personnel; provision for reporting injuries of the newborn and congenital malformations; a program for the prevention of crippling conditions; publication of educational material; establishment of consultation services and special laboratory services for use during epidemics; establishment of standards for qualifications of personnel, based on requirements of nationally recognized organizations; and establishment of standards for hospital care, based on the requirements of national hospital organizations.

State Agencies Administering Services for Crippled Children.

The type of State agency administering crippled children's services varies. State plans approved for the fiscal year 1936 were administered in 15 States by the department of health, in 10 by the department of public welfare, in 8 by a crippled children's commission, in 3 by the department of education, in 1 by an interdepartmental committee, and in 1 by a State university hospital.

Submission and Approval of State Plans.

Each State plan for services for crippled children, before it can be approved by the Chief of the Children's Bureau, must meet the conditions specified in section 513 of the Social Security Act. These conditions are as follows:

1. Financial participation by the State.
2. Administration or supervision of administration of the plan by a State agency.
3. Methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) necessary for the efficient operation of the plan.
4. Provision for furnishing reports to the Secretary of Labor.
5. Provision for medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or suffering from conditions leading to crippling.
6. Provision for cooperation with medical, health, nursing, and welfare groups and organizations, and with any State agency administering laws providing for vocational rehabilitation.

TABLE 4.—*Allotments and payments to States for services for crippled children under the Social Security Act, title V, part 2, 5 months ended June 30, 1936*

State [1]	Allotment available for payment of half the total expenditure under approved State plans [2]			Payment [3]
	Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration	
Total	[4] $1, 187, 000. 00	$424, 827. 45	[4] $762, 172. 55	$732, 492. 33
Alabama	23, 778. 14	8, 329. 95	15, 448. 19	17, 846. 21
Alaska	8, 606. 14	8, 329. 95	276. 19	1, 250. 00
Arizona	10, 608. 86	8, 329. 95	2, 278. 91	10, 608. 00
Arkansas	18, 878. 95	8, 329. 95	10, 549. 00	(5)
California	29, 908. 35	8, 329. 95	21, 578. 40	13, 758. 00
Colorado	13, 237. 15	8, 329. 95	4, 907. 20	9, 500. 00
Connecticut	15, 723. 11	8, 329. 95	7, 393. 16	(5)
Delaware	9, 396. 31	8, 328. 95	1, 068. 36	(5)
District of Columbia	10, 060. 69	8, 329. 95	1, 730. 74	5, 586. 68
Florida	15, 495. 67	8, 329. 95	7, 165. 72	15, 495. 00
Georgia	25, 112. 37	8, 329. 95	16, 782. 42	(5)
Hawaii	10, 419. 32	8, 329. 95	2, 089. 37	(5)
Idaho	10, 689. 85	8, 329. 95	2, 359. 90	8, 000. 00
Illinois	41, 525. 89	8, 329. 95	33, 195. 94	(5)
Indiana	23, 035. 84	8, 329. 95	14, 705. 89	(5)

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] The amount allotted to any State remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

[3] In 25 States the operation of the plan was to start Feb. 1 and payment was made on the basis of the full 5-month period. In 11 States with approved plans the dates of beginning operation were as follows: Mar. 1, Idaho, Kansas, Texas; Mar. 16, Minnesota; Apr. 1, District of Columbia, Massachusetts, Mississippi, New Hampshire, New Mexico, Ohio, Pennsylvania, and Utah; May 16, Colorado.

[4] Includes $90,511.91 unallotted to States. Certain States did not make requests for allotments from this fund because matching funds were not available or because the period was short for launching new programs. The balance in this fund was not available for allotment after June 30, 1936.

[5] Plan not approved.

TABLE 4.—*Allotments and payments to States for services for crippled children under the Social Security Act, title V, part 2, 5 months ended June 30, 1936*—Continued

State	Allotment available for payment of half the total expenditure under approved State plans			Payment
	Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration	
Iowa	$19, 814. 03	$8, 329. 95	11, 484. 08	(5)
Kansas	17, 266. 38	8, 329. 95	8, 936. 43	$9, 726. 64
Kentucky	27, 520. 10	8, 329. 95	19, 190. 15	26, 520. 10
Louisiana	19, 837. 01	8, 329. 95	11, 507. 06	(5)
Maine	12, 057. 36	8, 329. 95	3, 727. 41	12, 057. 36
Maryland	15, 883. 53	8, 329. 95	7, 553. 58	(5)
Massachusetts	26, 935. 75	8, 329. 95	18, 605. 80	21, 233. 00
Michigan	37, 000. 00	8, 329. 95	28, 670. 05	37, 000. 00
Minnesota	20, 542. 01	8, 329. 95	12, 212. 06	14, 379. 00
Mississippi	19, 974. 29	8, 329. 95	11, 644. 34	2, 487. 08
Missouri	24, 598. 00	8. 329. 95	16, 268. 05	24, 598. 00
Montana	10, 936. 63	8, 329. 95	2, 606. 68	7, 900. 00
Nebraska	25, 000. 00	8, 329. 95	16, 670. 05	25, 000. 00
Nevada	8, 690. 18	8, 329. 95	360. 23	(5)
New Hampshire	10, 368. 19	8, 329. 95	2, 038. 24	1, 500. 00
New Jersey	44, 803. 00	8, 329. 95	36, 473. 05	37, 494. 88
New Mexico	10, 786. 25	8, 329. 95	2, 456. 30	7, 500. 00
New York	64, 537. 00	8, 329. 95	56, 207. 05	61, 213. 00
North Carolina	32, 709. 00	8, 329. 95	24, 379. 05	32, 086. 00
North Dakota	12, 170. 59	8, 329. 95	3, 840. 64	(5)
Ohio	44, 650. 00	8, 329. 95	36, 320. 05	44, 650. 00
Oklahoma	21, 529. 23	8, 329. 95	13, 199. 28	21, 508. 33
Oregon	12, 286. 62	8, 329. 95	3, 956, 67	(5)
Pennsylvania	55, 639. 03	8, 329. 95	47, 309. 08	55, 639. 00
Rhode Island	11, 499. 70	8, 329. 95	3, 169. 75	3, 000. 00
South Carolina	19, 273. 29	8, 329. 95	10, 943. 34	8, 300. 00
South Dakota	12, 010. 74	8, 329. 95	3, 680. 79	12, 010. 74
Tennessee	25, 593. 00	8, 329. 95	17, 263. 05	25, 593. 00
Texas	49, 999. 92	8, 329. 95	41, 669. 97	49, 999. 92
Utah	11, 226. 52	8, 329. 95	2, 896. 57	7, 500. 00
Vermont	9, 986. 63	8, 329. 95	1, 656. 68	6, 665. 00
Virginia	21, 672. 65	8, 329. 95	13, 342. 70	21, 672. 57
Washington	14, 915. 00	8, 329. 95	6, 585. 05	14, 915. 00
West Virginia	26, 268. 27	8, 329. 95	17, 938. 32	26, 268. 27
Wisconsin	22, 258. 63	8, 329. 95	13, 928. 68	22, 258. 63
Wyoming	9, 772. 92	8, 329. 95	1, 442. 97	9, 772. 92

[5] Plan not approved.

Every State plan that was submitted provided for the development of State-wide services. In States where services were already in existence they were extended and improved so as to meet the requirements of the Social Security Act.

Since this was an entirely new program involving Federal and State cooperation, legislative or administrative action was necessary in a number of States before they could participate. Difficulties involved in such arrangements in some States caused delay in submission and approval of plans. No plan for the fiscal year 1936 was received from Arkansas, Delaware, Hawaii, Illinois, Louisiana, Nevada, or North Dakota. Plans for 1936 were submitted by Connecticut, Georgia, Indiana, Maryland, Iowa, and Oregon, but there were legal or administrative difficulties which prevented approval of these plans before the end of the fiscal year.

Between February 11 and June 30, 1936, 36 States, Alaska, and the District of Columbia submitted plans for services for crippled children which conformed to the requirements of the Social Security Act and were approved by the Chief of the Children's Bureau.

Allotments and Payments to States.

Table 4 shows the allotments and payments made to the States for the 5-month period ended June 30, 1936.

The amount of State, local, and private funds included in the State budgets for services for crippled children for the fiscal year 1936 exceeded the amount of Federal funds requested. The plans as approved showed $1,133,500 of State and local funds and requests for $747,484 from Federal funds. The State agencies were encouraged to include in their budgets all public funds used for services for crippled children, even though the total exceeded the amount needed to match the Federal funds requested. However, this was not done in all cases.

Of the amounts included in the budgets as approved, $911,130 was from State funds, $206,350 from local funds, and $16,020 from private funds made fully available for expenditure as public money. Although the amount of State and local funds available for matching exceeded the amount of Federal funds requested in a number of States (Florida, Kansas, Minnesota, New York, Ohio, Oklahoma, and Wisconsin), appropriations in several other States were relatively small, and these States were unable to request the total amount of Federal funds available for allotment to them.

Locating Crippled Children.

Although surveys to locate crippled children had not been made in all States, in most of them there were sufficient cases on record reported from public and private sources to enable the State agency to initiate extensive plans for diagnostic clinics and hospital care.

The school census in some States provides for a separate enumeration of crippled children. This has not always included children of preschool age, but efforts are being made to have this group included. In Maine a partial survey was conducted by the department of health, through the local health officers, during the early part of 1936. In Utah, where the program was new, questionnaires were filled in by county public-health nurses and social workers who obtained the information from physicians, schools, hospitals, and other organizations and agencies. In Montana, Idaho, and other States with new programs special efforts were made to collect reports of cases through both official and unofficial agencies. Incomplete returns from a survey in Cleveland of all persons who had had infantile paralysis as children indicated that a large number had never received any treatment.

The reporting on birth certificates of congenital malformations and injuries of the newborn makes early diagnosis and treatment possible. In New Jersey such reporting is required by State law. Through the courtesy of the State agency in New Jersey copies of the New Jersey law and report forms were forwarded to agencies in all other States.

An additional method of locating crippled children is through reports by public and private welfare or health agencies and by organizations such as the Shriners, the Elks, the American Legion, men's "service clubs," women's organizations, and interested individuals. Complete registration of all crippled children is not available in any of the States, but through the cooperation of the various groups registration records are being brought up to date.

Through the epidemiological reports of the State health departments the State crippled children's agencies are informed of cases of poliomyelitis.

Diagnostic Service.

Examination of crippled children is provided in the States through itinerant or permanent diagnostic clinics conducted by orthopedic surgeons in cooperation with local physicians and assisted by nurses, social workers, and volunteers. Clinics are held at intervals, the frequency depending on the locality and the number of children to be examined.

The State programs were often a continuance of programs already under way. For example, the Oklahoma Society for Crippled Children and the State vocational-rehabilitation division had conducted crippled children's clinics over a period of 10 years. Every county in the State had been reached and a total of 269 clinics had been held. Permanent orthopedic and plastic clinics had been established in two counties. The Oklahoma Commission for Crippled Children, created in 1935, is continuing these activities.

New York State has been divided into five districts (exclusive of New York City), and clinics have been so arranged and scheduled in each district that clinical services have been provided throughout these districts. A part-time district orthopedic surgeon is in charge of each of four districts, and the other district is served by surgeons from the central office.

Before Federal funds became available clinics in some States were usually held in hospitals; and transportation expense made it impossible to bring children from all over the State to such centers. Under the present plans itinerant clinics to serve even remote areas in these States are being arranged by the State agencies.

In many States clinics have been organized for providing treatment as well as diagnosis. This practice has proved to be of great value in reducing the length of hospital stay and in providing treatment for great numbers of crippled children who have been on waiting lists for prolonged periods. In South Carolina some of the combined diagnostic and treatment clinics are held at weekly intervals. In this State many cases of clubfoot have been successfully treated on the weekly clinic days without hospitalization, thus enabling the surgeons to take care of a greater number of patients with the funds available.

In a number of other States similar treatment clinics are in operation but are held at less frequent intervals. Services given include massage, muscle manipulation, measurements for and fitting of braces and artificial limbs, and instructions regarding further treatment in the home.

Six States in which the services were new reported that clinics had been held between February 1 and June 30, 1936, as follows: 3 in Colorado, 9 in Idaho, 12 in New Mexico, 6 in Rhode Island, 2 in South Dakota, 1 in Utah, and 1 in Washington. Alabama, Kentucky, Minnesota, Missouri, North Carolina, Ohio, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin reported that clinic service was increased and in some cases was extended to remote areas not previously reached. A total of 529 children were examined in the 9 clinics held in Idaho, and 186 of these children were recommended for hospitalization. In New Mexico 482 children were examined in the 12 clinics, 320 were recommended for hospitalization, and 68 of these were hospitalized. In North Carolina the State clinics provided examination, reexamination, and treatment (for the less severe types of crippling) for 556 children, and 57 children were admitted to selected general hospitals for treatment.[2]

A number of States that did not get their clinic programs under way by June 30 devoted time to organization work, selecting clinic centers and surgeons, and obtaining cooperation of local groups, so that they were ready to go ahead during the fiscal year 1937.

Acceptance for Care.

The methods by which applications are submitted to the State crippled children's agencies and acted upon differ.

In Ohio the application for care is made to the juvenile court by a parent, guardian, or other interested person. The social history is prepared by a juvenile-court worker, a local child-welfare worker, or a public-health nurse. If the parent or guardian is financially unable to care for a crippled child who is in need of treatment and if the State agency is able to accept the child for care, the court commits him to the agency for a year. At the expiration of the commitment the State agency makes a report to the juvenile court recommending renewal or termination of the commitment.

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[2] This does not include children who attended clinics conducted by the North Carolina Orthopedic Hospital, nor by Duke Hospital, nor children admitted to the North Carolina Orthopedic Hospital for treatment.

In Indiana, under a public-welfare law passed in 1936, a county board may recommend to the State board of public welfare that a crippled child whose parents are unable to provide treatment be admitted to the State hospital or to any public or private hospital for treatment. The county board acts upon the recommendation of a physician or surgeon and secures the consent in writing of the parent or guardian of the child. Upon receiving the recommendation from the county board, the State agency may apply to the State hospital for admittance of the child, or place him in any other public or private hospital with which it has contracted for care.

The decision with regard to the acceptance of responsibility for the care of a crippled child rests with the State agency. The agencies are trying to establish sound procedures leading to such a decision, such as considering the family's ability to pay for the medical treatment needed and making sure that the child is not under medical care when accepted.

In emergency the agencies make a special effort to speed the procedure so that medical care can be begun at once.

Surgical Care and Hospitalization.

After accepting a crippled child the State agency provides surgical and hospital care insofar as funds and facilities are available. Since public funds are to be used in paying for medical care, the State agency is responsible for the selection of surgeons with satisfactory professional qualifications. For hospital care the State agency must set standards for the approval of hospitals to which children may be sent and for the kind of care to be given. In establishing professional and hospital standards the State agencies have been using the requirements set by nationally recognized groups, including the American Board of Orthopedic Surgery, the American College of Surgeons, the American Medical Association, and the American Hospital Association.

In some cases only State-owned and State-operated hospitals have been used in the past. The new plans in a large number of States include the use, on an individual-case basis, of all public or private hospitals adequately equipped to give orthopedic care. This decentralization of hospital facilities makes it possible to hospitalize increased numbers of children and to give hospital service nearer the children's homes.

The Pennsylvania and Minnesota plans showed that local hospitals were to be used for short-term cases and that beds at the State hospitals were to be reserved for cases needing long-time care or specialized services. In Missouri, in the past, children were placed in the State university hospital. Under the new plan in this State agreements were drawn up with other approved hospitals, the State was divided into three districts based on ease of transportation, and in general children will be referred to the hospital most easily accessible. Other States are following similar procedures by treating children in local hospitals where facilities are available or by transporting them to other hospital centers for treatment of special types of crippling conditions.

The use of additional hospitals will reduce the waiting lists for hospitalization, which are distressingly long in many States. Since State registers were incomplete when the plans for the fiscal year 1936 were submitted and many children had not yet been examined in clinics, data on the number of children awaiting hospitalization as given in the plans were not comparable, State by State. Alabama reported an estimate of 9,000 crippled children in the State, including 900 children whose records, carried in the active files, showed need of hospitalization and treatment. Kansas estimated the number of crippled children in need of care at 2,000. The Michigan estimate showed 1,000 children who had never had hospital care, and 4,000 who had had some hospital care but needed further hospitalization. Nebraska reported a total of 1,979 children under 16 years of age eligible for care for whom records were on file, with an estimate of 6,500 such children in the entire State. New Hampshire reported 460 crippled children under 16 years of age, of whom 84 children were under treatment. North Carolina reported 1,200 children who had been examined and who were waiting for hospitalization at the end of the fiscal year. Reports from other States also indicated large numbers of children in need of hospitalization or other treatment.

The number of cases that can be given care is influenced by the average length of time children are kept in the hospital. The average length of stay, reported by only a few States, ranged from 15 days up to 9 months. Information on length of stay in the hospital was too incomplete to permit any definite conclusion, but it was evident that in a number of States the time might be reduced by the use of carefully selected convalescent homes and boarding homes.

Convalescent Care.

Plans for convalescent care for crippled children following hospitalization differ from State to State. On the whole, the 1936 plans showed that the State agencies in many cases were not yet ready to develop this phase of service to meet the recognized need.

Convalescent homes under public or private auspices are used in a number of States. In Birmingham and Mobile, Ala., for example, certain citizens are providing buildings for convalescent care for crippled children. In Ohio there are six convalescent homes in the State, and two hospitals give a "convalescent rate" after 21 days' care. Each of these convalescent institutions has a pediatrician on the staff and, with one exception, a complete physical-therapy department. In Massachusetts a State sanatorium and a State hospital school are used for convalescent care. In New York 15 convalescent homes are used.

In Wisconsin, through the combined efforts of the interdepartmental committee for crippled children's services and the State department of education, two additional orthopedic schools were established, in connection with which treatment and education are combined. For children who live at a distance from such schools board is paid in homes located near the schools, so that they are enabled to receive medical and nursing care, physical training, and schooling. These children do not lose contact with their own families as in most cases arrangements are made for them to spend week ends at home.

Aftercare Services.

For cases that do not need the intensive care given in convalescent institutions, aftercare is given in the child's own home, wherever possible, or in a well-selected foster home.

The State agency arranges for the child's return home and for the transmitting of the physician's instructions to the local public-health nurse or other local worker who is to advise and instruct the parents on how to care for the child. Physical therapy may be provided by a local physical therapist, or a physical therapist from the State staff may instruct the local public-health nurse and the mother on the care to be given. Medical and surgical supervision are provided through return visits to the operating surgeon or by bringing the child to the State clinic when it is held in the neighborhood of the child's home. The local child-welfare worker may be called upon to arrange for the child's return to school and for his participation in normal neighborhood activities.

As the program in many States had been in operation for a relatively short time by June 30, 1936, plans for follow-up services had not been completely developed. A number of States, however, reported that provision for follow-up services, through use of Federal funds, had met one of the great needs in their programs.

In New Mexico the official agency is responsible for obtaining written instructions from the orthopedic surgeon and seeing that they are forwarded to the local public-health nurse who is responsible for aftercare. The field representatives of the State child-welfare agency prepare social-history summaries for the public-health nurses.

In Massachusetts physical therapy is given through the out-patient departments of State hospitals.

In Kansas six field districts were created, and by June 30, 1936, five nurses had been employed for these districts. The nurses are responsible for locating crippled children and for work with the orthopedic surgeon in the aftercare of cases under his supervision. Such nursing service was new in the State. The State agency soon became aware of increased interest in crippled children in the districts in which the nurses were working.

In Ohio visits to the children's homes are made by four orthopedic nurses working in the four districts into which the State is divided. For foster-home care only homes licensed and investigated by the State department of public welfare are used. In Minnesota aftercare in the homes is done by a field staff of public-health nurses, some of whom have had physical-therapy training. Whenever the State agency administering service for crippled children finds that care in a foster home is needed, the State children's bureau cooperates by investigating and recommending foster homes.

Medical Service.

The program for services for crippled children is a medical-care program involving many social problems. In addition to performing professional services, members of the medical profession are associated with the program as administrators and members of advisory committees.

In about one-half of the States with approved plans the program was directed by a physician. In other States where administrative direction was given by nurses, social workers, or other executives, there was close cooperation with the State health departments and the medical profession.

By June 30, 1936, general advisory committees, including representatives of the medical profession in their membership, had been appointed in most of the States. Technical advisory committees composed of medical members had been appointed in about two-thirds of the States.

Problems in connection with standards for selection of surgeons, pediatricians, and physicians to whom children are to be referred for care are referred by the State agency to the general advisory committee or to a technical advisory committee. In most instances, the qualifications recommended by such committees as a basis for selecting surgeons and pediatricians are those recommended by the Children's Bureau advisory committee on services for crippled children and by the State and Territorial health officers. (See pp. 41–42.)

Physicians and surgeons providing service are paid on a part-time salary basis or on a fee basis. In a few States medical services are given without compensation.

Nursing Service.

In most of the States public-health nurses have been appointed to the staff of the State crippled children's agency. They function in a liaison capacity between the State agency and the local public-health nurses throughout the State, offering consultation service on the orthopedic aspects of public-health nursing.

Trained to recognize deviations from the normal in children, the public-health nurse, through her home and school visits, has an opportunity to recognize early symptoms that may lead to serious crippling and to bring such children to diagnostic and treatment clinics. The local public-health nurse frequently assists in organizing and conducting clinics for crippled children, and in arranging with the parents and the State agency for sending the child to the hospital, where surgical care can be given. The local public-health nurse also plays an important part in the aftercare program, which includes explaining to the parents the kind of care the child needs and arranging for the child's further supervision by the orthopedic surgeon.

The supervising nurses and the district nurses employed by the State agency teach the public-health nurses the orthopedic phases of their work and supplement the local nursing service where necessary.

In an effort to get well-qualified public-health nurses for the State positions, emphasis is being placed on orthopedic-nursing courses and experience in addition to the public-health-nursing courses and experience prescribed in the standards of the National Organization for Public Health Nursing. Study of orthopedic nursing, either as part of the nurse's basic preparation or in postgraduate courses, or supervised experience in orthopedic nursing in a public-health-nursing agency, is now considered an important qualification of candidates for appointment on the staff of a State crippled children's agency. If the nurse is to give physical-therapy service, approved courses in this type of care are also needed. In some States stipends are being given to nurses to enable them to obtain additional training for orthopedic nursing.

Physical Therapy.

Physical therapy has heretofore been available in connection with hospitals, convalescent homes, and crippled children's schools, but such service has seldom been available to children in small towns and rural communities. By the close of the fiscal year 1936 a few crippled children's agencies had placed physical-therapy technicians on their State staff, in some States to give service to children and in others to teach mothers and local public-health nurses how to give physical therapy to convalescent children. There probably will be steady development in the provision of this type of service by the State agencies.

Social Service.

Plans for 16 States showed social workers on the State crippled children's staff; in six of these States the program was directed by a social worker. Social workers employed in the field assisted in locating crippled children, in planning for clinics, and in working out arrangements with State and local welfare organizations for social case-work services. There has been a growing interest in the use of medical social workers who are especially trained to study the family situation of a child in relation to his illness and to work out correlated plans to meet the social problems connected with medical care. In order to make medical care and the necessary supplementary services equally available to all crippled children—in remote areas as well as in cities—medical social workers are assisting in the development of programs and policies with regard to effective procedures for serving the individual child.

In selecting medical social workers, standards formulated by the American Association of Medical Social Workers are used in many States.

Vocational Rehabilitation.

The Social Security Act requires that the State crippled children's agency cooperate with the State vocational-rehabilitation service. In Alabama, Mississippi, and Texas the State crippled children's service and the vocational-rehabilitation service are both under the State department of education, and they exchange information in an effort to provide well-planned vocational training for physically restored children. In other States referral of cases from one service to the other is arranged for and other cooperative activities are planned.

Cooperation With Public and Private Agencies.

The general State advisory committees previously mentioned, which include representatives of medical, health, welfare, nursing, and educational groups, have been appointed in a majority of the States, and technical advisory committees representing the medical profession have also been appointed in many cases. For example, in California a professional advisory committee, with a northern and a southern group of members, has been appointed, and also a lay advisory committee.

A distinctive feature of most of the State plans is the coordination of the work of public and private agencies concerned with services for crippled children.

Cooperation with State health departments has been described. (See p. 42.)

State departments of education and local school authorities provide special educational facilities for crippled children in a number of States through the use of special schools and through bedside teaching. In certain States arrangements have been made for mental testing in the schools.

The State departments of public welfare, through State field workers or through county units, cooperate in locating crippled children, in operation of clinics, in making social case studies when needed, and in arranging for aftercare services.

The assistance given by private groups in funds, transportation, and personal interest has enabled State agencies to extend the facilities for hospitalization and other essential services. In many States organizations, such as the Shriners and the Elks, maintain hospitals where crippled children are treated free of charge or on the payment of a nominal sum by the official agency. The Junior League in Tennessee and in Oklahoma operates convalescent homes and in West Virginia assists at clinics. State societies for crippled children, the American Legion, women's organizations, men's "service clubs," and other groups assist at clinics, provide transportation for children, and make other contributions which broaden the range of services and conserve the funds of the official agency. In some States special rates are given by railroads and busses for transportation of children to clinic or hospital centers.

In Seattle, Wash., an orthopedic hospital supported by private funds has been the principal organization in the State giving services for crippled children from birth to 14 years of age. By agreement with this hospital, the State examines all children from birth to 21 years of age in diagnostic clinics, and provides hospitalization for children from 14 to 21 years of age. The private hospital provides treatment for children under 14, and the State agency accepts the responsibility for aftercare of children of both groups.

In New Jersey the Elks have been active in the past in providing services for crippled children, and arrangements have been made for correlation of their work with that of the official agency. The Shriners cooperate in paying for hospitalization and in providing maintenance while the child is away from home to get vocational training; the Rotary and Kiwanis Clubs take an interest in children who are receiving vocational training and endeavor to get employment for them afterwards. These organizations supplement the work of the State agency, and they frequently provide services that are outside the scope of the public program.

State Research Projects.

In States where programs are well established and the waiting list for hospitalization is small, an intensive study is being made of the methods of locating crippled children and of the results of treatment. The New Jersey plan included a special project for the study and care of cases of cerebral palsy. The Michigan Crippled Children's Commission is making a study of the results of the care given children, especially in rural areas, over the last 10 years.

Increased Service Under 1936 Plans.

Before the plans for services for crippled children under the Social Security Act were developed, in a number of States no State agency was provided for such services. In others public funds were available for only one type of service, such as hospitalization. All the State plans for the fiscal year 1936 showed, as required by the act, the development of additional services and the extension of services to rural areas or to areas showing special need.

Progress in the States under the Social Security Act can be measured in part by the extent to which the State administrative staff has been strengthened and the extent to which services have been provided throughout the State. A total of 122 staff members were added in 33 States.[3] These included 33 nurses, 10 physical therapists, and 17 social workers. A large proportion of these new members of the State staffs were employed to do field work throughout the State. The plans as made provided for appointment of additional personnel, particularly field workers, but the short time the plans were in operation made it impossible for the State agencies to select qualified persons for all the positions planned for.

Fifteen physicians or surgeons were added as regular staff members, and a large number of orthopedic surgeons and other physicians were to be used in the programs for diagnostic and operative services on a part-time basis.

By June 30, 1936, the State plans had been in operation only 5 months or less. The following information from State reports shows the progress already made by the States:

In Florida the number of cases hospitalized during the 5-month period covered by the 1936 plan increased about 50 percent as compared with the same period in 1935. The scope of the work was broadened to include cases of harelip and of cleft palate. One orthopedic surgeon was added to the staff, and, during the succeeding fiscal year, two more surgeons and three nurses were to provide more adequate treatment and follow-up.

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[3] This does not include orthopedic surgeons or physicians engaged on a part-time basis for diagnostic or operative services.

Kentucky reported an increase in the number of children given treatment from February through June as compared with the corresponding period in 1935. One clinic was held in a rural community where no previous clinic had been held. Children stricken with poliomyelitis in 1935 had been given a total of 259 physical-therapy treatments. Additional field staff provided more adequate follow-up service.

In Michigan a new field district had been created, with a nurse in charge; this permitted closer supervision and better follow-up service. Through the addition to the staff of a statistical clerk more frequent evaluations of the work will be possible.

Until 1936 the crippled children's program in Minnesota had been almost entirely one of surgical care in the State hospitals and of itinerant clinics. There had been no field follow-up work and no provision for convalescent care or aftercare. The expanded program includes decentralization of hospital services by the planned use of various private hospitals and the development of case-finding services, convalescent-care facilities, and follow-up services by the field staff. The program will extend services over the State. A department of field nursing service was organized, clinics were held, and, in addition to children placed in the State hospital, 30 were placed in private hospitals during the time the 1936 plan was in operation.

The situation in Missouri was similar to that in Minnesota. Good but quantitatively inadequate services had been provided by the State university hospital. The use of other hospitals to serve the eastern and the western sections of the State and the development of diagnostic and follow-up services will insure a State-wide program and more adequate services. Two field nurses were employed and the field staff was to be increased during 1937.

In South Dakota funds had been limited, and therefore work for crippled children had been sporadic. The new program was slow in starting, but during the 2 months of operation under the 1936 plan 38 children were given care, as compared with 68 during the 2-year period ended June 30, 1934.

In South Carolina the number of orthopedic centers was increased from 1 to 4, the number of hospitals from 1 to 6, and the number of diagnostic and operative clinics held monthly was increased from 4 to 10. The services of a physical therapist were used for the first time in the State program. As in a number of other States, the training of staff was included in the program.

The grant of Federal funds to Texas made possible better care of convalescents through the addition of three nurses to the State staff, reported by the State to be a pressing need. The volume of work had been doubled and the service had improved. Additional social workers, nurses, and a physical therapist were placed on the staff.

In New Jersey a program for care of crippled children has been in operation for a number of years. A special effort was started under the new program to recheck all cases of crippled children in the State. The director of the program met with a special committee of the board of each political subdivision so that cooperation could be arranged in order to have all cases cleared through the crippled children's commission. A recheck of cases by the nurse in charge had been undertaken in each jurisdiction.

The program in Arizona was entirely new, and the time during the first 3 months of operation was devoted to locating crippled children, appointing advisory committees, and providing for certification of orthopedic surgeons and hospitals in preparation for future work. A few emergency cases were given care.

In Colorado also the program was new. The State child-welfare bureau had made a survey of crippled children in 1933–34. The new program administered by the division of public health was built in part on the survey findings. A general advisory committee was appointed and a physician and two medical social workers were placed on the staff. Three diagnostic clinics were held in June 1936.

Administrative Problems Ahead.

There are a number of administrative problems to be worked out. Some of these problems have been discussed with the Children's Bureau advisory committees and will receive further attention at future meetings of these committees. Among the subjects that require special consideration are the following:

1. Types of crippling conditions found in different parts of the country, the number of each type, and the kind and extent of care which should be provided under the joint Federal-State program.
2. Duration of hospital care required, development of convalescent facilities, not only to shorten hospitalization but to make the transition from the hospital to the home easier for the child, and extension of aftercare to make medical treatment more effective, through the services of nurses and medical social workers.
3. Costs of medical care, including professional fees, hospital charges, and cost of appliances.
4. Standards for hospitals and convalescent homes.
5. Qualifications of professional personnel, including the extent to which standards developed by national professional organizations are being followed in State programs.

6. Reporting systems that will indicate accurately the numbers of crippled children in need of care, the types of crippling conditions found, and services being provided.

7. Functions of the general advisory committees and of medical committees acting in an advisory capacity to the State agency.

8. Use of medical social workers in an effort to provide the family service needed in connection with locating crippled children and arranging for medical care, convalescent care, and aftercare and to coordinate health and welfare services in State and local programs.

9. Policies and procedures with regard to acceptance by the State agency of crippled children for care.

10. Provision in hospitals and convalescent homes for discharge procedures based on consideration of the family situation of the child and of the resources available in his community.

11. Working relationships between vocational-rehabilitation, public-health, and crippled children's services.

12. Provision for diagnosis and treatment of children suffering from cerebral palsy resulting from birth injuries, and results of treatment of such children.

13. Development of popular material concerning the causes and prevention of crippling conditions.

14. Methods of providing immediate care for children suffering from poliomyelitis.

CHILD-WELFARE SERVICES [1]

Part 3 of title V of the Social Security Act authorizes an annual appropriation of $1,500,000 for Federal grants to the States to enable the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, child-welfare services for the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent. The funds are to be used for payment of part of the cost of district, county, or other local child-welfare services and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and in areas of special need.

The first appropriation for grants to the States for these purposes was $625,000 for the 5-month period ended June 30, 1936.

The provisions of the Social Security Act relating to child-welfare services vary in several particulars from those relating to maternal and child-health services and services for crippled children. The act provides that the amounts allotted by the Secretary of Labor to the States for child-welfare services shall be for use by cooperating State public-welfare agencies on the basis of plans developed jointly by the State agency and the Children's Bureau.

The act defines only in general terms the requirements which the States are to meet in submitting State plans when they request Federal aid for child-welfare services. The State's share of the Federal appropriation is to be expended for payment of part of the cost of local child-welfare services and for developing State services as specified, but the act does not require dollar-for-dollar matching of any part of the funds.

The emphasis on providing services in rural areas is stronger in this portion of the act than in the other two. The distribution of the larger part of the fund for grants for child-welfare services is on the basis of rural population, and the funds to be used for local services are to be expended primarily for child-welfare services in predominantly rural areas.

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[1] The information in this section is for the fiscal year 1936 (5 months, Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

Children's Bureau Administrative Service.

The Child Welfare Division of the Children's Bureau, including a Director, an Associate Director, and five regional social-work consultants, was established to work with the State public-welfare agencies in formulating the State plans to be submitted for the approval of the Chief of the Children's Bureau and to give consultation service to the States in the conduct of the plans as approved.

By March 31, 1936, contact had been established between the Child Welfare Division and each of the 48 States and the District of Columbia, either through visits to the States by members of the staff or through interviews in the Washington office. By June 30, 1936, every State had been visited at least once and a considerable number more than once, by a field consultant or by the Director or the Assistant Director of the Child Welfare Division. There had also been correspondence between the Chief of the Children's Bureau and the Governors of Alaska and Hawaii, but no plans for child-welfare services had been received from these Territories up to June 30, 1936, because neither had a Territorial public-welfare agency.

The method followed by the Children's Bureau and each State public-welfare agency in developing jointly plans for child-welfare services was to determine the existing situation in each State and to formulate a plan conforming to the provisions of the act and providing for maximum service to the children to be served. No effort was made to outline a uniform plan to which all the States would be expected to conform.

An effort was made by the State agencies and the Children's Bureau to set up objectives for a long-range child-welfare program and to include in each State plan such portions of this program as appeared to be possible of accomplishment during the period for which the plan was made.

Advisory Service.

The advisory committee on community child-welfare services made two reports outlining objectives and organization for child-welfare services, which were valuable to the Children's Bureau and to the State public-welfare agencies in formulating plans and procedures for carrying out plans.

At its first meeting, December 16 and 17, 1935, the advisory committee listed as child-welfare services needed in rural communities the following types of service, which are needed in any locality:

1. Arranging for foster-home care or institutional care for children who need care away from their own homes.
2. Protecting neglected children and those suffering from mistreatment or exploitation.
3. Finding, and securing the necessary attention for, children handicapped by physical defects.

4. Finding the mentally defective children who are in need of custodial care or training, safeguarding those in the community when necessary, and supervising those on parole from schools.
5. Safeguarding children of illegitimate birth.
6. Providing investigation and case-work services for courts handling cases of neglect, transfer of custody, and adoptions.
7. Assisting courts without full-time probation service by investigating complaints and supervising children on probation.
8. Cooperating with State children's institutions with reference to admissions and aftercare service.
9. Providing case-work services for mental-hygiene clinics.
10. Assisting schools in dealing with attendance and conduct problems.
11. Organizing or cooperating in community activities for the prevention of juvenile delinquency.
12. Arranging for care in appropriate institutions or foster homes for dependent or defective children found in institutions not equipped for such care.

The committee emphasized the importance of including in State plans adequate provision for both State and local services. It was the opinion of the committee that since funds available would not in most cases permit development of uniform local programs in all parts of the State, emphasis might be placed on the development of services in certain areas on a demonstration basis, looking forward to the complete assumption of responsibility by the State or by local units as soon as possible, thus making funds available for services in other areas. The committee placed particular emphasis on the importance of a basic general public-welfare program in which the child-welfare program would have its proper place.

With reference to State services, the committee agreed that one or more of the following activities might be included in State plans, depending on the situation in the State, the financial resources available, and the services already provided:

1. Assistance in developing community child-welfare activities in counties, districts, or other areas.
2. Consultant service to local units or areas on special problems of child care.
3. Local demonstrations of methods of conducting child-welfare services and developing sound relationships between such services and other social-welfare activities.
4. Cooperation with child-health services, in connection with clinics for promoting physical and mental health and providing child-guidance facilities.
5. Conferences and institutes, local or regional.
6. Assistance in developing and promoting professional training for child-welfare work.
7. Special studies and research, such as studies of population and intake of institutions and child-placing agencies in relation to community child-welfare services available.
8. Statistical services affording current information on child-welfare problems in relation to community child-welfare programs.

The advisory committee on community child-welfare services agreed that, depending on State and local conditions, plans for local service in rural areas might include (1) sharing in paying for salaries and travel of welfare workers (in a general public-welfare program) who devote part-time to child-welfare service, (2) employment of specialized child-welfare workers to serve as part of a unit having general social-welfare functions, and (3) provision for specialized local child-welfare services where no provision for family social service exists, pending development of a unified welfare program.

At its second meeting, held in June 1936, the advisory committee included in its report a statement of basic principles for the development of child-welfare services which constitutes a significant contribution to the philosophy of programs for services to dependent and neglected children.

State Public-Welfare Agencies.

The Social Security Act requires the Children's Bureau to cooperate with State public-welfare agencies in administering the program for child-welfare services.

Prior to the date when the first Federal appropriation for this purpose became available (Feb. 11, 1936), the Children's Bureau, through its Child Welfare Division, conferred with State officials in each State to determine which State agency would be the one to cooperate in the administration of child-welfare services.

Some States had a department of public welfare that was clearly responsible for services to children. In some States the only organization that could be termed a State public-welfare agency was the relief administration. When direct Federal relief was terminated, this agency became the nucleus for the further development of a State public-welfare agency. In some States a special session of the legislature was called for the purpose of enacting laws to enable the State to cooperate with the Federal Government in the administration of the social-security program. In other States, pending legislative action, the Governor by executive order authorized such cooperation between the State relief authority and the Federal Government. In a few States no agency had been authorized by June 30, 1936, to carry on the cooperative child-welfare-service program.

On June 30, 1936, there were, broadly speaking, four types of State agencies with which the Children's Bureau was cooperating in the administration of child-welfare services. These were as follows: (1) State departments or boards of public welfare in which there had been no recent changes of function; (2) State departments or boards of public welfare reorganized to include relief functions; (3) newly organized State departments of public welfare having relief functions; and (4) State relief administrations, authorized by executive order or by special legislation to cooperate with the Federal Government in carrying out the purposes of the Social Security Act.

Submission and Approval of State Plans.

By June 30, 1936, the plans presented by 33 States and the District of Columbia had been approved by the Chief of the Children's Bureau, and Federal payments had been made to these States.

Allotments and Payments to States.

Table 5 shows the allotments and payments made to 33 States and the District of Columbia for child-welfare services for the 5-month period ended June 30, 1936.

Of the 17 States and Territories that did not receive grants for child-welfare services for the fiscal year 1936, all but 6 received grants for the fiscal year 1937 (see table 10, p. 91). The amounts available annually for grants for child-welfare services to the States which did not participate in the program for child-welfare services during the fiscal years 1936 and 1937 are shown on page 89.

TABLE 5.—*Allotments and payments to States for child-welfare services under the Social Security Act, title V, part 3, 5 months ended June 30, 1936*

State [1]	Allotment [2]			Payment
	Total	Uniform allotment	Allotment on basis of ratio of rural population in State to total rural population	
Total	$408, 819. 31	$141, 666. 78	$267, 152. 53	$227, 954. 12
Alabama	18, 684. 34	4, 166. 67	14, 517. 67	18, 684. 34
Arizona	6, 347. 53	4, 166. 67	2, 180. 86	6, 300. 00
California	15, 743. 21	4, 166. 67	11, 576. 54	1, 883. 00
Delaware	5, 046. 24	4, 166. 67	879. 57	1, 790. 00
District of Columbia	4, 166. 67	4, 166. 67	----------	1, 666. 30
Florida	9, 574. 10	4, 166. 67	5, 407. 43	6, 255. 07
Idaho	6, 575. 05	4, 166. 67	2, 408. 38	4, 348. 61
Kansas	12, 953. 44	4, 166. 67	8, 786. 77	12, 953. 40
Louisiana	13, 845. 70	4, 166. 67	9, 679. 03	4, 153. 71
Maine	7, 799. 31	4, 166. 67	3, 622. 64	1, 881. 63
Maryland	9, 178. 89	4, 166. 67	5, 012. 22	7, 336. 00
Massachusetts	7, 358. 67	4, 166. 67	3, 192. 00	3, 250. 00
Michigan	15, 923. 31	4, 166. 67	11, 756. 64	10, 102. 50
Minnesota	14, 137. 86	4, 166. 67	9, 971. 19	11, 300. 00
Missouri	17, 678. 87	4, 166. 67	13, 512. 20	9, 225. 00
Montana	6, 888. 34	4, 166. 67	2, 721. 67	2, 062. 50
Nebraska	10, 974. 15	4, 166. 67	6, 807. 48	8, 572. 84
Nevada	4, 598. 64	4, 166. 67	431. 97	842. 57
New Hampshire	5, 633. 83	4, 166. 67	1, 467. 16	4, 971. 68
New Jersey	9, 525. 68	4, 166. 67	5, 359. 01	1, 896. 67
New Mexico	6, 582. 50	4, 166. 67	2, 415. 83	6, 582. 00
North Carolina	22, 183. 69	4, 166. 67	18, 017. 02	12, 126. 89
Ohio	20, 496. 02	4, 166. 67	16, 329. 35	6, 983. 00
Oklahoma	16, 183. 66	4, 166. 67	12, 016. 99	2, 260. 20
Oregon	7, 708. 65	4, 166. 67	3, 541. 98	964. 44
Pennsylvania	27, 812. 30	4, 166. 67	23, 645. 63	5, 440. 00
South Dakota	8, 455. 94	4, 166. 67	4, 289. 27	5, 040. 00
Texas	30, 388. 63	4, 166. 67	26, 221. 96	27, 349. 74
Utah	6, 010. 66	4, 166. 67	1, 843. 99	3, 450. 00
Vermont	6, 005. 02	4, 166. 67	1, 838. 35	3, 372. 46
Virginia	16, 656. 56	4, 166. 67	12, 489. 89	8, 930. 00
Washington	9, 348. 34	4, 166. 67	5, 181. 67	9, 300. 00
West Virginia	13, 613. 97	4, 166. 67	9, 447. 30	11, 079. 00
Wisconsin	14, 739. 54	4, 166. 67	10, 572. 87	5, 600. 57

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[1] The term "State" includes Alaska, District of Columbia, and Hawaii.

[2] The amount of funds allotted to each State with an approved plan remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

Characteristics of State Plans.

In the development of State plans, differing conditions in the several States were taken into consideration in order that the funds available might be used, within the limitations of the law, for purposes that would contribute most to the development of the child-welfare program in each State. Although every plan provided for the extension and strengthening of State services, for the encouragement and assistance of community child-welfare organization, and for the development of additional local facilities, there were marked variations within this general framework, due to the differences in existing child-welfare programs. The outstanding features of the plans may be summarized as follows:

> Extending and strengthening existing State field services in order that local units may be aided in providing more adequate social resources for the care and treatment of children.
>
> Organizing county or district units which might include a demonstration of intensive case work with children.
>
> Making provision for in-service training of staff through methods best suited to the needs in each State and encouraging selected staff members who have had at least a beginning in basic training in social work to obtain additional professional training, specializing in child-welfare work.
>
> Coordinating child-welfare services with other phases of public-welfare services for which county welfare departments are responsible.
>
> Stimulating interpretation of the need for child-welfare services through enlisting the interest of public officials, lay groups, individuals, and representatives of other social agencies in securing more adequate resources for the care of children. This activity included planning for county and regional conferences designed to stimulate interest in community participation in the child-welfare program.
>
> Planning for special consideration of the needs of Negro children either by the addition of a Negro worker to the staff of the State department or of a demonstration unit or by including in the plan provision for adding such service later.
>
> Developing State and local committees with both professional and lay members to advise on the program.

Emphasis on Rural Areas.

The Social Security Act in providing for child-welfare services, as previously indicated, specifically states that the funds are to be used for furthering the development of services in areas predominantly rural. The members of the President's Committee on Economic Security had data showing that numbers of children living in rural communities throughout the country have been consistently neglected because facilities for health and social services were lacking in their communities. Thus, in the drafting of the bill which became the Social Security Act, emphasis was placed upon the development of such services near the child's home. For this reason the Children's Bureau, in planning with States for the administration of child-welfare services, has placed emphasis upon need for (1) a local unit of welfare administration and (2) unified service within that unit in order that services for children might not be too widely separated from other phases of public-welfare service.

Related Programs.

In initiating the new program the Children's Bureau has made every effort to correlate the services for which it is responsible with the services administered by the Social Security Board, the Public Health Service, the Works Progress Administration, the Office of Indian Affairs, the Rural Resettlement Administration, and other Federal agencies, and with the services of private national agencies such as the Child Welfare League of America and the American Public Welfare Association.

Special emphasis was placed upon coordinating the program for child-welfare services with the programs for maternal and child-health services and services for crippled children, which are also administered by the Children's Bureau. In one State, for example, the children's case workers employed in the program for child-welfare services are giving special attention to the social needs of crippled children coming to the attention of the health department and the department of education. In another State, in which the State department of health has set up a child-health demonstration in a rural county, the State welfare department has assigned to the same county a children's case worker, whose salary is paid out of child-welfare-service funds.

The policy of making the field consultants on the staff of the Child Welfare Division available to the Crippled Children's Division for consultation service on the social aspects of programs for crippled children has been in operation since the inception of the two divisions within the Children's Bureau.

State and Local Personnel.

During the first months when the Children's Bureau began making payments to States for child-welfare services, various problems emerged. One of these had to do with securing properly qualified personnel. It seems obvious that there is little point in investing money for services for children unless that money is used to purchase service that is sufficiently skillful to produce constructive results. There is considerable feeling in some of the States against the importation of out-of-State persons, and, at the same time, there is a dearth of local workers who are qualified. For this reason many of the plans presented included provision for further training of workers already on the job and for encouraging workers to secure additional professional training. Through the use of advisory committees for both State and local programs, it is hoped that there will come an increasing appreciation of the importance of entrusting a child-welfare program only to persons who have the kind of training and experience which warrants their participation in a program shaping the lives of children who are unable to speak for themselves. The following statement from the report of the Children's Bureau advisory committee on community child-welfare services is pertinent at this point:

> * * * It is essential that personnel be secured which will be capable of organizing programs, of introducing and developing standards, of recognizing the needs of children, and of resourcefully developing remedies. The benefits to be derived from the program of child-welfare services now being set up by the various States in cooperation with the Federal Children's Bureau will accrue in exact proportion to the extent to which its administration is entrusted to persons selected solely because they are capable of securing the results which are sought.

Reports on State Activities.

During the experimental and developmental stages of the child-welfare-service program the Children's Bureau did not ask the States for detailed statistical reports on activities. Simple financial reports, showing expenditures and balances for the 5-month period, and a general statement regarding progress made in carrying out the original plans approved were all that the States were requested to furnish.

The importance of relating statistical reporting and research to the social objectives of the child-welfare program and of correlating its reporting system with those for aid to dependent children, for relief, and for other social-welfare activities under the local administrative unit became increasingly clear as the Social Security Act began to be translated into action. Data that will be of benefit to the local unit are of primary importance; second in importance are data from local units that will help the State welfare departments to understand social conditions in the State and to plan constructive methods of dealing with problems discovered; and third in importance are data that should be obtained by a Federal agency from all States for purposes of summary and comparison.

In relation to child-welfare services under the act, the Children's Bureau for the present will continue to request general reports, in such form as seems desirable to each State, on important projects undertaken and on progress made.

State Progress, February–June 1936.

The major effort and accomplishment of the first 5-month period of the program of Federal aid to the States for child-welfare services were the formulation and initiation of State plans. Each of the cooperating States, after the plan was approved, had to find additional child-welfare workers for the State staff, and the ground work had to be laid for the local projects.

The reports from the State agencies for the period ended June 30, 1936, showed substantial progress in putting the plans into effect, especially in establishing child-welfare services in local communities. A summary made shortly after June 30, 1936, showed that in 308 counties or districts (in 4 States the districts are composed of several towns) child-welfare services had been put into operation with the use of Federal funds supplemented by local funds. Workers attached to the State welfare departments were providing general child-welfare services and some case work for individual children in 192 additional counties in order to demonstrate the necessity for more extensive local work.

Local staff paid in full or in part from Federal funds included 271 social workers. Full-time service was being given by 133 workers and part-time service by 96 workers employed by State welfare departments for assisting local units and organizing State-wide activities.

The following excerpts from progress reports submitted by the State agencies, covering the initial period of development of child-welfare services under the act, illustrate more clearly the mode of procedure and the type of advances made under the program:

> In order to intensify the field service for children's work, three children's case consultants * * * have been attached to the field staff. One of these consultants accompanies the field representative, who is responsible for advising the county public-welfare units on all phases of their program, on the regular routine visit to the county. The consultant remains in the county for a week or 10 days following the visit of the field representative. In this way routine supervision of children's work is facilitated because basic and fundamental policies are being interpreted more carefully than the field representative has had the time to do. The needs of the county staffs have been illuminated for the State staff by this consultation service.
>
> For demonstration purposes our plan includes four special areas, each area consisting of four counties. In each area there has been placed a community worker, whose responsibility lies in the field of further development of community resources for child welfare. There was no pattern for the development of a plan of community organization, since this State has done very little in this specific field. The workers have had a major interest in the development of recreational facilities and in encouraging volunteer leadership. They have made library facilities available to children in remote hamlets. They have worked out cooperative arrangements with other agencies and have established wholesome community relationships. They have been received enthusiastically in the rural areas, and there is evidently a field of service here. The time has come, after the several months that the plan has been in progress, when we realize that we must define relationships with other agencies more clearly and stake out in greater detail the next steps in the development of this service.

> The counties, in general, are eagerly taking advantage of the State-wide program. The larger counties are starting special training programs for their staffs in child welfare, conducted either by the county case supervisor or by a specially designated member of the social-service staff. One of the

objectives of the State welfare program is the setting up of a permanent integrated service of public-welfare and child-welfare services. The State and district staff workers * * * have all been working to this end. The response from the counties, in general, is good. The county staffs are interested in endeavoring to develop public-welfare activities on a modern basis, including special stress on child-welfare services. The State welfare agency is giving financial aid to the counties to enable them to keep social-work staffs qualified to carry on not only relief activities but child-welfare services also. It is requiring the counties to have staffs which meet the personnel standards outlined by the State, to conduct their case work on an acceptable level, and to give full consideration to child-welfare problems and needs.

Each of the 64 parish welfare units was told of the proposed plan for child-welfare services, and they were asked to submit cases which they felt should be carried by a child-welfare worker. They were also asked to designate all children not living in their own homes, on the schedules sent to the State office, as a basis for the study of cases eligible for aid to dependent children.

After considerable discussion among members of the State staff, with county workers and board members, with members of the board of State aid and charities, individual social workers in State social agencies interested in the State program, with institutional workers, child-placing workers, juvenile-court judges, and so forth, a bulletin in regard to child-welfare services was sent out to all county welfare boards in the State. In response to the bulletin, various county welfare boards have discussed preliminary plans with the division of county organization and field supervision after careful study and discussion with local community agencies in regard to potential developments. As a result of this local activity, the State office went through the process of preliminary planning for the final setting up of child-welfare services.

On July 1, 1936, there were 10 district case workers, responsible for child-welfare cases, assigned to districts throughout the State. This includes 2 case workers assigned to handle child-welfare cases in one of the larger cities. Two counties have been selected as "demonstration counties" under the program for child-welfare services. A case worker was assigned to one of these counties, to begin work on the demonstration June 25, 1936.

From April 20 to June 30 some progress was made in establishing local child-welfare services, strengthening existing State services, securing local cooperation, and developing relationships with agencies in allied fields. No separate local child-welfare advisory committees were formed, on account of the fact that it is planned to utilize the advisory committee on crippled children's services in each county as an advisory committee on child-welfare services also. On June 1 there were employed and in the field five district supervisors.

In one county the county judge considered the children's case worker chiefly as a probation officer and tended to swamp her with problem cases. * * * He volunteered the statement that such cases as he had been sending would take time and that progress would be gradual. He also pointed out that under some circumstances the case would probably show little response to treatment and that the community should be made to realize this. Increasingly he has been able to visualize the possibilities of a broad, county-wide, children's program. He * * * is planning with the worker as to how the county may give adequate and continued financial assistance in the child-welfare program.

In the counties without a local worker the field worker acquainted the county welfare office with the service now available through child-welfare services and gave advice and assistance on cases involving child-welfare problems. County judges were interviewed, as they handle mothers' pension cases and juvenile delinquency and are members of the county child-welfare boards under the State child-welfare commission. * * * Facts were gathered as to number of mothers receiving a "mothers' pension," the lowest and highest amount given in each county, and the basis on which the aid is given, whether according to a set schedule based on the number in the family or on the family's individual need. Even these meager facts showed a need for better administration if the State receives funds under the Social Security Act for aid to dependent children. The field worker found no paucity of cases, as every county welfare office had from 3 or 4 to 15 or 20 cases needing immediate attention.

The plan of this State for carrying out the provisions of the Social Security Act concerning child-welfare services is a training program, the objective of which is to provide workers in rural areas with an opportunity for training and supervision while handling actual child-welfare cases. * * * The present training program began April 1 of this year (1936). Eight workers were released from eight different counties and brought to the State capital for training. In addition, one field supervisor joined the group. * * * The original program of training was set up to include a discussion of general principles of child-welfare work and the use and development of community resources plus actual experience in children's case work. However, since none of the students had had any professional training, the plan was altered to include a short period of intensive discussion, covering the nature and scope of the whole field of social work and the principles of social case work. Each student carried from five to seven cases. The cases were selected because of the particular children's problems involved. Three agencies were used as a source for case material; namely, the county department of public welfare, the juvenile court, and the department of education.

A demonstration of the need of general child-welfare services was started March 15 (1936) under the direction of a trained social-service worker. If there was any doubt of the need of child-welfare services in her vicinity, it has already vanished. The worker has been successful in fostering the interest of local groups, including officials and lay persons who can be depended upon to develop an intelligent public opinion leading to coordination of local effort. She has been given office space in the county courthouse and is being called for conferences with the judge and the State's attorney on juvenile cases. She finds the Works Progress Administration nursing service invaluable, and one community has a fund for the medical care of its children. She has had contact with 46 families, 2 of which live where they cannot be reached by car, even in good weather, while 10 live back in the hills on roads which are extremely rough but still passable during the summer months.

Problems and Objectives.

Since the program for child-welfare services centers around providing funds for additional personnel for States and local communities which will enable them to give more adequate service to individual children, it is clear that this program will not be worth the investment in it unless properly qualified persons are employed.

In the field of public health there is complete acceptance of the necessity for employing physicians and public-health nurses for medical and nursing service. Acceptance of the professional status of social work is not as yet general. Therefore, it is difficult to explain to public officials and to citizens' groups why interest in children and good intentions are not the only qualifications necessary for a child-welfare worker. Sometimes it is difficult to make people see that training for social work is necessary because only through the employment of qualified personnel can a standard of service be maintained which safeguards the personality of the individual coming to an agency for help.

One of the problems which must be faced in the immediate future is that of securing competent personnel. It will be necessary for some time to carry on in-service training projects and to provide for "educational leave" in order that workers having basic qualifications may attend professional schools of social work. Even though the Children's Bureau is now cooperating with most of the States for the purpose of providing services for children in rural communities, this does not mean that all the personnel problems have been solved. As new plans are developed in each State, the importance of selecting efficient persons for child-welfare services must be continually stressed in order that the purpose of the act may not be defeated by crude and ignorant treatment of children.

The child-welfare-service program is of necessity a demonstration program in selected areas. Its value lies not only in the direct service which will be rendered to children in the areas selected for demonstration but also in the stimulation given to children's services in other areas. To be successful, therefore, the program for child-welfare services must be accompanied by a continuous analysis of the value of various methods and procedures used in dealing with children's problems and by presentation of such experience to the communities concerned and to other communities. Such a presentation will undoubtedly lead other counties and local districts to set up or to strengthen their own programs for child-welfare services.

As the local child-welfare demonstrations operated with Federal and State aid prove their worth, the county or other local area benefited should assume increasing financial responsibility for such child-welfare services. The available Federal and State funds thus released can then be used to aid other communities in establishing adequate child-welfare programs.

Government structure and administration in the child-welfare program are important only as they unloose forces that will make it possible for more children to have a satisfactory family life and greater opportunities for the development of their capacities. The Children's Bureau and the State child-welfare agencies have a responsibility for helping all workers participating in the program to focus their attention upon what is happening to children rather than to permit themselves to become absorbed in the machinery that they are operating.

PRELIMINARY SUMMARY OF ACTIVITIES IN THE FISCAL YEAR 1937

The State plans submitted and approved for each of the three social-security programs administered by the Children's Bureau for the fiscal year ended June 30, 1937, were for the most part a continuance and an extension of the 1936 plans. While a full report cannot be made on the activities carried on under the 1937 plans until reports for the fiscal year are in, significant developments are already apparent.

Maternal and Child-Health Services.

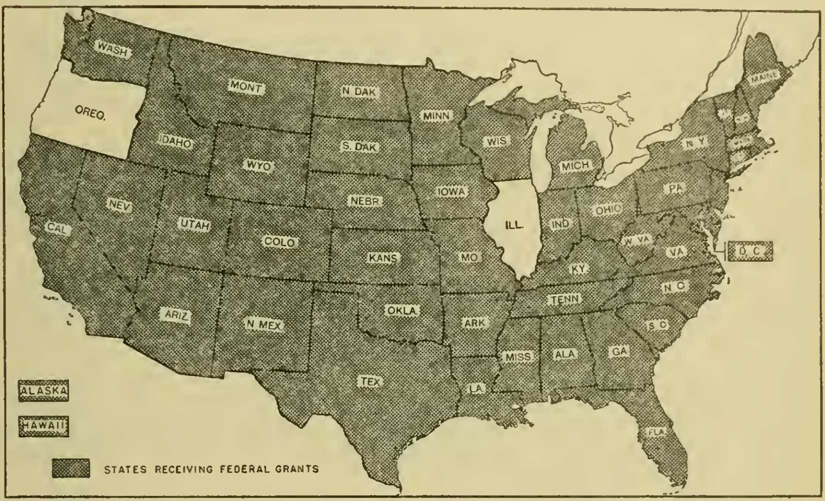
For the fiscal year 1937 State plans for maternal and child-health services were approved and were in operation for all the 48 States, Alaska, Hawaii, and the District of Columbia. (For States receiving grants, see fig. 1 and table 6.)

In every State a division of maternal and child health is functioning as a major unit of the State health department. In 45 States a physician is the full-time director of the division and in 3 States the part-time director. Three States budgeted for a full-time medical director, but the positions had not been filled by the end of the fiscal year (June 30, 1937).

In the plans submitted by the States for the fiscal year 1937 an average of only 37 percent of the total expenditures for State maternal and child-health programs was budgeted from State funds; 63 percent was budgeted from Federal funds. For local maternal and child-health programs 18 percent was budgeted from State funds, 48 percent from local funds, and 34 percent from Federal funds. (See table 7.)

Figure 1.—*Maternal and child-health services; States receiving Federal grants as authorized by the Social Security Act, title V, part 1, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937

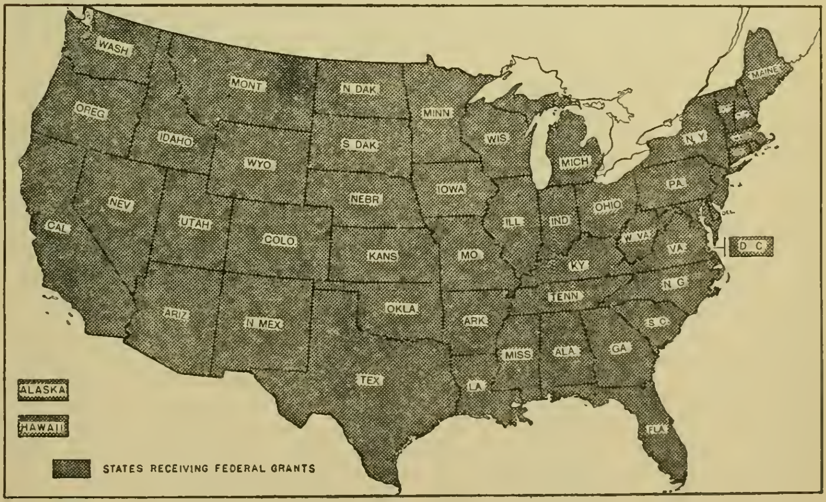


TABLE 6.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for maternal and child-health services under the Social Security Act, title V, part 1, fiscal year ended June 30, 1937*

State [1]	Federal funds available						Federal funds budgeted in State plans as approved	Payment		
	Total	Balance of Fund A available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937					Total	FUND A	FUND B
			Total	FUND A Available for payment of half the total expenditures (except from fund B) under approved State plans [3]		FUND B Allotment on basis of need for assistance in carrying out State plan after number of live births is taken into consideration				
				Uniform allotment	Allotment on basis of ratio of live births in State to total live births					
Total	$4,379,849.40	$584,450.51	$3,795,398.89	$1,020,000	$1,800,000.00	[4] $975,398.89	$3,736,104.23	$2,989,014.72	$2,191,001.70	$798,013.02
Alabama	103,217.66	.10	103,217.56	20,000	52,470.16	30,747.40	103,217.56	102,446.14	72,470.16	29,975.98
Alaska	45,337.91	7,743.16	37,594.75	20,000	1,057.75	16,537.00	21,100.00	15,945.22	3,885.33	12,059.89
Arizona	52,558.28	2,231.90	50,326.38	20,000	7,017.52	23,308.86	52,558.28	51,735.02	29,249.42	22,485.60
Arkansas	80,155.39	6,985.78	73,169.61	20,000	31,001.15	22,168.46	80,155.39	70,071.78	50,345.81	19,725.97
California	121,658.24	34,015.31	87,642.93	20,000	64,742.54	2,900.39	87,867.54	51,599.79	50,049.40	1,550.39
Colorado	72,620.81	13,933.41	58,687.40	20,000	14,749.83	23,937.57	71,093.24	60,788.70	36,851.13	23,937.57
Connecticut	46,328.23	2,970.48	43,357.75	20,000	18,357.75	5,000.00	46,328.23	41,634.86	37,422.90	4,231.96
Delaware	33,282.31	4,211.60	29,070.71	20,000	3,295.55	5,775.16	33,282.31	32,059.65	26,284.49	5,775.16
District of Columbia	35,104.41	51.69	35,052.72	20,000	8,376.88	6,675.84	35,104.41	32,328.61	28,428.57	3,900.04
Florida	75,239.17	4,289.79	70,949.38	20,000	22,077.22	28,872.16	75,239.17	65,978.07	42,077.22	23,900.85
Georgia	144,565.39	3,896.16	140,669.23	20,000	53,433.72	67,235.51	144,565.39	132,076.81	73,433.72	58,643.09
Hawaii	43,669.49	4,070.77	39,598.72	20,000	7,681.09	11,917.63	43,669.49	42,630.93	30,847.15	11,783.78
Idaho	47,941.05	5,389.51	42,551.54	20,000	7,745.54	14,806.00	47,941.05	39,518.90	26,646.07	12,872.83
Illinois	157,275.73	46,188.60	111,087.13	20,000	91,087.13	------------	86,232.50	70,144.50	70,144.50	------------
Indiana	82,448.16	19,188.67	63,259.49	20,000	43,259.49	------------	69,818.50	47,845.42	47,845.42	------------
Iowa	75,880.96	11,368.96	64,512.00	20,000	35,090.03	9,421.97	51,752.31	42,728.06	37,936.92	4,791.14
Kansas	68,884.00	13,037.65	55,846.35	20,000	26,826.35	9,020.00	61,526.00	28,702.16	25,063.24	3,638.92
Kentucky	92,826.70	5,300.29	87,526.41	20,000	49,502.68	18,023.73	92,470.88	87,170.59	69,146.86	18,023.73
Louisiana	93,028.22	3,731.39	89,296.83	20,000	35,536.27	33,760.56	92,668.89	88,924.43	55,176.94	33,747.49
Maine	55,610.10	5,074.56	50,535.54	20,000	13,023.54	17,512.00	54,357.00	36,999.27	24,425.88	12,573.39
Maryland	53,807.64	------------	53,807.64	20,000	22,592.88	11,214.76	53,807.64	53,239.74	42,592.88	10,646.86

Massachusetts	83, 559. 34	8, 186. 47	77, 372. 87	20, 000	52, 745. 35	4, 627. 52	83, 559. 34	79, 175. 21	74, 547. 69	4, 627. 52
Michigan	115, 891. 93	16, 597. 57	99, 294. 36	20, 000	69, 352. 85	9, 941. 51	114, 901. 51	84, 440. 68	75, 303. 41	9, 137. 27
Minnesota	71, 796. 43	2, 361. 83	89, 434. 60	20, 000	37, 947. 60	11, 487. 00	69, 434. 00	67, 506. 15	57, 947. 00	9, 559. 15
Mississippi	113, 429. 16	8, 732. 50	104, 696. 66	20, 000	39, 552. 41	45, 144. 25	113, 428. 75	104, 698. 25	59, 552. 00	45, 144. 25
Missouri	93, 700. 14	14, 791. 62	78, 908. 52	20, 000	48, 908. 52	10, 000. 00	51, 591. 06	43, 467. 27	33, 467. 27	10, 000. 00
Montana	47, 494. 32	2, 340. 80	45, 153. 52	20, 000	8, 221. 52	16, 932. 00	47, 494. 32	42, 599. 52	28, 221. 52	14, 378. 00
Nebraska	57, 664. 13	16, 934. 72	40, 729. 41	20, 000	20, 729. 41	----------	22, 330. 00	1, 997. 05	1, 997. 05	----------
Nevada	68, 797. 19	8, 449. 90	60, 347. 29	20, 000	1, 185. 01	39, 162. 28	40, 372. 28	28, 557. 03	798. 50	27, 758. 53
New Hampshire	43, 090. 12	7, 012. 44	36, 077. 68	20, 000	6, 502. 68	9, 575. 00	32, 575. 00	27, 022. 79	20, 693. 98	6, 328. 81
New Jersey	89, 921. 22	18, 915. 61	71, 005. 61	20, 000	45, 070. 88	5, 934. 73	80, 934. 73	75, 481. 94	69, 573. 33	5, 908. 61
New Mexico	70, 467. 96	8, 510. 51	61, 957. 45	20, 000	10, 551. 87	31, 405. 58	70, 467. 96	61, 003. 47	30, 551. 87	30, 451. 60
New York	239, 440. 93	57, 422. 48	182, 018. 45	20, 000	153, 386. 10	8, 632. 35	211, 181. 57	78, 655. 04	75, 553. 58	3, 101. 46
North Carolina	146, 402. 26	8, 550. 04	137, 852. 22	20, 000	65, 864. 75	51, 987. 47	137, 852. 22	116, 362. 25	70, 202. 18	46, 160. 07
North Dakota	59, 324. 15	11, 272. 74	48, 051. 41	20, 000	12, 022. 81	16, 028. 60	36, 931. 10	28, 974. 34	17, 621. 81	11, 352. 53
Ohio	144, 566. 78	29, 430. 44	115, 136. 34	20, 000	82, 719. 34	12, 417. 00	96, 378. 00	83, 456. 11	79, 308. 94	4, 147. 17
Oklahoma	88, 689. 87	9, 603. 64	79, 086. 23	20, 000	39, 088. 82	19, 997. 41	68, 272. 41	64, 333. 76	45, 439. 11	18, 894. 65
Oregon	51, 121. 51	12, 808. 86	38, 312. 65	20, 000	10, 806. 41	7, 506. 24	27, 441. 25	27, 441. 25	19, 950. 00	7, 491. 25
Pennsylvania	240, 312. 74	63, 372. 39	176, 940. 35	20, 000	132, 415. 40	24, 524. 95	156, 100. 00	50, 813. 96	50, 813. 96	----------
Rhode Island	39, 712. 59	5, 447. 52	34, 265. 07	20, 000	8, 552. 07	5, 713. 00	33, 783. 00	31, 409. 34	26, 097. 34	5, 312. 00
South Carolina	101, 016. 00	139. 81	100, 876. 19	20, 000	36, 579. 13	44, 297. 06	101, 016. 00	98, 994. 68	56, 718. 94	42, 275. 74
South Dakota	59, 577. 04	8, 804. 49	50, 772. 55	20, 000	10, 885. 73	19, 886. 82	38, 584. 30	27, 021. 32	7, 802. 49	19, 218. 83
Tennessee	95, 875. 85	----------	95, 875. 85	20, 000	43, 295. 85	32, 580. 00	95, 875. 85	92, 295. 27	63, 295. 85	28, 999. 42
Texas	219, 774. 06	29, 183. 20	190, 590. 86	20, 000	96, 356. 86	74, 234. 00	190, 590. 00	129, 543. 93	78, 034. 20	51, 509. 73
Utah	58, 135. 45	12, 090. 41	46, 045. 04	20, 000	10, 441. 98	15, 603. 06	53, 088. 61	43, 045. 03	30, 441. 97	12, 603. 06
Vermont	51, 174. 43	9, 391. 75	41, 782. 68	20, 000	5, 448. 24	16, 334. 44	30, 834. 44	23, 312. 53	13, 746. 58	9, 565. 95
Virginia	91, 968. 13	1, 747. 68	90, 220. 45	20, 000	43, 280. 96	26, 939. 49	91, 968. 13	76, 718. 57	63, 280. 96	13, 437. 61
Washington	54, 687. 20	1, 137. 33	53, 549. 87	20, 000	18, 626. 31	14, 923. 56	54, 687. 20	47, 895. 91	38, 626. 31	9, 269. 60
West Virginia	73, 846. 33	3, 713. 24	70, 133. 09	20, 000	34, 272. 74	15, 860. 35	73, 846. 33	68, 616. 78	54, 272. 74	14, 344. 04
Wisconsin	76, 603. 79	6, 094. 91	70, 508. 88	20, 000	42, 490. 96	8, 017. 92	76, 603. 79	64, 878. 61	58, 642. 45	6, 236. 16
Wyoming	50, 368. 50	9, 725. 83	40, 642. 67	20, 000	3, 772. 37	16, 870. 30	31, 245. 30	24, 710. 03	8, 174. 66	16, 535. 37

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[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount of this fund allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

[4] Of the $980,000.00 authorized for allotment, $4,601.11 was not allotted.

TABLE 7.—*Estimated expenditures for maternal and child-health services under the Social Security Act, title V, part 1, as shown by budgets included in approved State plans for fiscal year ended June 30, 1937*

[Supplements and complete revisions included; amendments since approval not included]

State	Total estimated expenditures	Expenditures for State purposes		Expenditures for local purposes		Expenditures for State purposes				Expenditures for local purposes					
						From State funds		From Federal funds		From State funds		From local funds		From Federal funds	
		Amount	Per cent	Amount	Per cent	Amount	Per cent	Amount	Per cent	Amount	Per cent	Amount	Per cent	Amount	Per cent
Total	$7, 507, 565. 01	$4, 367, 157. 48	58	$3, 140, 407. 53	42	$1, 610, 514. 84	37	$2, 756, 642. 64	63	$552, 398. 99	18	$1, 522, 055. 76	48	$1, 065, 952. 78	34
Alabama	222, 065. 36	30, 574. 40	14	191, 490. 96	86	6, 932. 84	23	23, 641. 56	77	21, 407. 62	11	90, 507. 34	47	79, 578. 00	42
Alaska	25, 663. 00	14, 700. 00	57	10, 963. 00	43	2, 000. 00	14	12, 700. 00	86	2, 563. 00	23	-----	-----	8, 400. 00	77
Arizona	88, 723. 06	39, 704. 06	45	49, 019. 00	55	7, 200. 00	18	32, 504. 06	82	9, 290. 00	19	17, 829. 00	36	21, 900. 00	45
Arkansas	145, 908. 46	53, 308. 46	37	92, 600. 00	63	14, 765. 00	28	38, 543. 46	72	16, 775. 00	18	34, 125. 00	37	41, 700. 00	45
California	230, 416. 59	75, 697. 54	33	154, 719. 05	67	8, 680. 00	11	67, 017. 54	89	-----	-----	133, 869. 05	87	20, 850. 00	13
Colorado	118, 248. 91	52, 293. 91	44	65, 955. 00	56	22, 015. 67	42	30, 278. 24	58	25, 140. 00	38	-----	-----	40, 815. 00	62
Connecticut	89, 720. 00	89, 720. 00	100	-----	-----	42, 380. 00	47	47, 360. 00	53	-----	-----	-----	-----	-----	-----
Delaware	93, 149. 50	31, 067. 95	33	62, 081. 55	67	9, 330. 84	30	21, 737. 11	70	48, 536. 00	78	-----	-----	13, 545. 55	22
District of Columbia	102, 360. 25	102, 360. 25	100	-----	-----	61, 087. 77	60	41, 272. 48	40	-----	-----	-----	-----	-----	-----
Florida	157, 968. 80	99, 321. 80	63	58, 647. 00	37	41, 100. 00	41	58, 221. 80	59	3, 480. 00	6	27, 917. 00	48	27, 250. 00	46
Georgia	289, 463. 62	178, 173. 62	62	111, 290. 00	38	48, 000. 00	27	130, 173. 62	73	-----	-----	77, 930. 00	70	33, 360. 00	30
Hawaii	100, 448. 44	100, 448. 44	100	-----	-----	53, 551. 71	53	46, 896. 73	47	-----	-----	-----	-----	-----	-----
Idaho	83, 837. 30	54, 132. 30	65	29, 705. 00	35	19, 765. 65	37	34, 366. 65	63	14, 750. 00	50	-----	-----	14, 955. 00	50
Illinois	172, 465. 00	157, 602. 50	91	14, 862. 50	9	71, 370. 00	45	86, 232. 50	55	-----	-----	14, 862. 50	100	-----	-----
Indiana	161, 156. 47	102, 934. 50	64	58, 221. 97	36	33, 116. 00	32	69, 818. 50	68	-----	-----	58, 221. 97	100	-----	-----
Iowa	94, 082. 65	64, 062. 31	68	30, 020. 34	32	12, 310. 00	19	51, 752. 31	81	-----	-----	30, 020. 34	100	-----	-----
Kansas	114, 467. 54	87, 925. 79	77	26, 541. 75	23	31, 064. 79	35	56, 861. 00	65	-----	-----	21, 876. 75	82	4, 665. 00	18
Kentucky	166, 649. 00	60, 725. 00	36	105, 924. 00	64	23, 262. 50	38	37, 462. 50	62	-----	-----	51, 255. 62	48	54, 668. 38	52
Louisiana	151, 656. 17	59, 359. 67	39	92, 296. 50	61	4, 490. 78	8	54, 868. 89	92	18, 315. 00	20	36, 181. 50	39	37, 800. 00	41
Maine	91, 202. 00	46, 042. 00	50	45, 160. 00	50	11, 111. 00	24	34, 931. 00	76	22, 496. 00	50	3, 238. 00	7	19, 426. 00	43
Maryland	180, 680. 39	30, 196. 39	17	150, 484. 00	83	15, 280. 00	51	14, 916. 39	49	54, 298. 00	36	54, 436. 00	36	41, 750. 00	28
Massachusetts	170, 829. 00	170, 829. 00	100	-----	-----	86, 700. 00	51	84, 129. 00	49	-----	-----	-----	-----	-----	-----
Michigan	219, 861. 51	163, 611. 51	74	56, 250. 00	26	48, 710. 00	30	114, 901. 51	70	56, 250. 00	100	-----	-----	-----	-----
Minnesota	200, 700. 00	67, 034. 00	33	133, 666. 00	67	23, 400. 00	35	43, 634. 00	65	4, 750. 00	4	103, 116. 00	77	25, 800. 00	19
Mississippi	184, 980. 75	127, 380. 75	69	57, 600. 00	31	42, 752. 00	34	84, 628. 75	66	9, 600. 00	17	19, 200. 00	33	28, 800. 00	50
Missouri	94, 156. 06	65, 731. 06	70	28, 425. 00	30	22, 090. 00	34	43, 641. 06	66	-----	-----	20, 475. 00	72	7, 950. 00	28
Montana	84, 724. 00	29, 184. 00	34	55, 540. 00	66	8, 054. 00	28	21, 130. 00	72	4, 548. 00	8	21, 852. 00	39	29, 140. 00	52
Nebraska	44, 660. 00	44, 660. 00	100	-----	-----	22, 330. 00	50	22, 330. 00	50	-----	-----	-----	-----	-----	-----
Nevada	41, 082. 28	19, 932. 28	49	21, 150. 00	51	960. 00	5	18, 972. 28	95	-----	-----	-----	-----	21, 150. 00	100
New Hampshire	55, 575. 00	55, 575. 00	100	-----	-----	23, 000. 00	41	32, 575. 00	59	-----	-----	-----	-----	-----	-----
New Jersey	384, 452. 73	126, 434. 73	33	258, 018. 00	67	59, 900. 00	47	66, 534. 73	53	38, 899. 00	15	204, 719. 00	79	14, 400. 00	6
New Mexico	112, 921. 71	46, 692. 96	41	66, 228. 75	59	4, 225. 00	9	42, 467. 96	91	150. 00	(1)	38, 078. 75	58	28, 000. 00	42
New York	414, 092. 75	309, 688. 40	75	104, 404. 35	25	107, 740. 00	35	201, 948. 40	65	47, 886. 00	46	47, 886. 00	48	8, 632. 35	8

North Carolina	223, 716. 97	202, 116. 97	90	21, 600. 00	10	85, 861. 75	42	118, 252. 22	58	-----	-----	-----	-----	21, 600. 00	100
North Dakota	57, 833. 60	36, 203. 35	63	21, 630. 25	37	5, 050. 00	14	31, 153. 35	86	150. 00	1	15, 702. 50	72	5, 777. 75	27
Ohio	181, 418. 00	74, 998. 00	41	106, 420. 00	59	12, 990. 00	17	62, 008. 00	83	8, 913. 00	9	63, 137. 00	59	34, 370. 00	32
Oklahoma	116, 547. 41	78, 897. 41	68	37, 650. 00	32	39, 750. 00	50	39, 147. 41	50	8, 525. 00	23	-----	-----	29, 125. 00	77
Oregon [2]	50, 054. 41	14, 764. 16	29	35, 290. 25	71	5, 026. 66	34	9, 737. 50	66	-----	-----	17, 586. 50	50	17, 703. 75	50
Pennsylvania	334, 928. 00	334, 928. 00	100	-----	-----	178, 828. 00	53	156, 100. 00	47	-----	-----	-----	-----	-----	-----
Rhode Island	61, 853. 00	00, 853. 00	98	1, 000. 00	2	27, 070. 00	44	33, 783. 00	56	-----	-----	1, 000. 00	100	-----	-----
South Carolina	163, 254. 00	128, 222. 00	79	35, 032. 00	21	25, 000. 00	19	103, 222. 00	81	-----	-----	35, 032. 00	100	-----	-----
South Dakota	49, 331. 62	40, 586. 82	82	8, 744. 80	18	12, 270. 00	30	28, 316. 82	70	2, 452. 40	28	-----	-----	6, 292. 40	72
Tennessee	197, 654. 50	31, 722. 50	16	165, 932. 00	84	9, 412. 50	30	22, 310. 00	70	34, 730. 00	21	56, 942. 00	34	74, 280. 00	45
Texas	308, 071. 00	154, 022. 00	50	154, 049. 00	50	27, 032. 00	18	126, 990. 00	82	21, 638. 00	14	68, 811. 00	45	63, 600. 00	41
Utah	90, 574. 16	40, 584. 16	45	49, 990. 00	55	13, 690. 55	34	26, 893. 61	66	23, 795. 00	48	-----	-----	26, 195. 00	52
Vermont	45, 334. 44	25, 817. 17	57	19, 517. 27	43	13, 800. 00	53	12, 017. 17	47	700. 00	4	-----	-----	18, 817. 27	96
Virginia	241, 684. 63	123, 068. 13	51	118, 616. 50	49	71, 690. 00	58	51, 378. 13	42	34, 560. 30	29	43, 466. 20	37	40, 590. 00	34
Washington	116, 897. 03	42, 157. 79	36	74, 739. 24	64	5, 885. 00	14	36, 272. 79	86	-----	-----	50, 379. 24	67	24, 360. 00	33
West Virginia	173, 679. 85	53, 472. 35	31	120, 207. 50	69	10, 095. 00	19	43, 377. 35	81	11, 050. 00	9	62, 402. 50	52	46, 755. 00	39
Wisconsin	149, 290. 38	141, 290. 38	95	8, 000. 00	5	70, 781. 50	50	70, 508. 88	50	-----	-----	-----	-----	8, 000. 00	100
Wyoming	57, 073. 71	26, 348. 71	46	30, 725. 00	54	7, 623. 33	29	18, 725. 38	71	6, 751. 67	22	-----	-----	23, 973. 33	78

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[1] Less than 1 percent.

[2] 6-month budget.

Thirty-five State health agencies included in their 1937 budgets funds for the payment of local practicing physicians on a part-time basis for conducting prenatal or child-health conferences. This has meant during the current year a considerable extension of these conference services into towns and rural areas where they did not exist before and has insured the participation of a large number of physicians in the maternal and child-health program. Many States and communities now recognize that the payment of physicians for this type of service is as important in rural areas as it is in cities, where this plan has long been followed.

In 28 States a total of 54 dentists were employed on the State staff, as well as 38 dental hygienists and 4 dental-health instructors. There is a growing tendency toward the employment of dentists on the staff of the State health agency, either in the division of maternal and child health or in a coordinate dental-hygiene division.

The State health officers again recognized in the 1937 State plans the basic importance of the service rendered by the public-health nurse in the maternal and child-health program. The State agencies are encouraging the employment of public-health nurses, usually with the county or the local governmental unit bearing a considerable proportion of the cost. Nursing service at time of delivery was planned in 21 States. Nurses participating in such service have special training and experience in obstetric nursing. Maternity-nursing institutes have been held in four States. Many nurses have been awarded stipends enabling them to study public-health nursing and also maternity nursing. Plans are being made to develop further facilities for courses in maternity nursing, combining experience in hospital- and home-delivery service. Effort is being directed toward the inclusion of preparation for service to infants during the neonatal period. Continuous supervisory service through the preschool period is being encouraged, so that upon entering school the child's physical defects will have been corrected. The content of school nursing service is receiving attention in many of the States.

There has been a distinct advance in the employment of nutritionists by State health agencies. Under the 1937 State plans 12 State health agencies employed a total of 23 nutritionists, of whom 20 are attached to maternal and child-health divisions.

Seven State health agencies employed health educators—a total of 11.

Forty-one States conducted postgraduate courses in obstetrics or pediatrics for local physicians during the fiscal year ended June 30, 1937. As instructors for such courses, the State agencies are taking great care to obtain obstetricians and pediatricians who are qualified to teach local general practitioners and to discuss their problems. Eight States had a total of 12 such instructors as full-time employees on the staff of the maternal and child-health division; 14 States engaged lecturers residing in their own State only; 13 States engaged out-of-State lecturers only; 6 States engaged both local and out-of-State lecturers. Such instructors are available at the request of local medical societies for consultation and demonstration clinics. The State agencies are receiving many requests for the extension and improvement of the program for postgraduate instruction of physicians.

Reporting to the Children's Bureau by the State agencies of current statistics of maternal and child-health activities began with the quarter July 1 to October 31, 1936. (See p. 38.) Some State agencies could not send in complete reports at the start because it was necessary to readjust the local reporting systems in order to obtain data in the form requested. It was expected that by July 1, 1937, every State would be in a position to assemble and send in comparable data on maternal and child-health activities.

For the first year State reports were requested only from areas where Federal maternal and child-health funds were being expended. For the fiscal year beginning July 1, 1937, reports are to be requested covering all local areas, with the intention of securing as soon as possible complete reports of maternal and child-health activities for each State. Separate entries will be requested for the areas in which the State health agency is conducting maternal and child-health demonstration services.

In January 1937 a 2-day conference was held at the Children's Bureau, with representatives of State health agencies present, to discuss medical and nursing record forms for maternal and child-health services. Subsequently the Children's Bureau prepared tentative forms for maternity-service records and for infant and preschool-service records. These were sent to the State agencies for comment. When the final form for each record is agreed upon copies will be printed for optional use in the States.

One outstanding fact revealed by the experience of the first year of operation of the maternal and child-health program is that although there has been marked extension of child-health and prenatal services, the State agencies have not been able with the funds available to provide to any extent for better care of the mother and infant at the time of birth. A number of State agencies have inquired as to the feasibility of including in their State plans provision for paying local physicians, on a case basis, to provide obstetric and pediatric care or consultation service for patients otherwise unable to obtain such service. The costs of such service and the funds so far available for the whole program have made it apparent that such expenditure can be undertaken only in a few small areas. The year's experience has made it increasingly evident, however, that there is urgent need in many areas for the provision of more adequate maternal care, including prenatal, natal, and postnatal care and care of newborn infants, by qualified local physicians, assisted by public-health nurses with special training. Inability to obtain such care is due to many factors, among them low economic status of the family, distance from physicians and hospitals, poor transportation facilities, and the inadequate undergraduate and graduate obstetric training of many practicing physicians.

In recognition of this need the general advisory committee on maternal and child-welfare services (Apr. 7 and 8, 1937) made recommendations to the Chief of the Children's Bureau and the Secretary of Labor proposing the extension of the maternal and child-health program under the Social Security Act by the provision of public funds to make available (1) increased and improved maternity care and care of the newborn and (2) training in these fields for physicians and nurses. The recommendations proposed provision of resources for: (1) Maternal care, to be given locally by qualified general practitioners and public-health nurses to women who could not otherwise obtain such care, (2) expert obstetric and pediatric consultation service to aid general practitioners in areas where such service is not otherwise available, and (3) delivery care in hospitals for women who because of medical, social, or economic reasons should be so cared for. In the development of such an extended program the committee recognized the right of the patient to select her own physician. The recommendations proposed also the establishment of centers of postgraduate education to teach urban and rural physicians and nurses the principles of complete maternal and infant care.

Similar recommendations were approved by the conference of State and Territorial health officers April 9, 1937, in adopting a joint report of its committee on maternal and child health and the child-hygiene committee of the Conference of State and Provincial Health Authorities of North America. This report also included a recommendation that the Children's Bureau send a questionnaire to the States on present facilities and resources for maternal and child health.

Services for Crippled Children.

For the fiscal year ended June 30, 1937, State plans for services for crippled children were approved for 42 States, Alaska, Hawaii, and the District of Columbia. (For States receiving grants see fig. 2 and table 8.)

Every State has designated an official agency for administering these services. The question of what State agency was best equipped to conduct them was considered by 1937 legislatures in many States, and in some the services were transferred from one agency to another. In Maryland the responsibility for the services was transferred from the board of State aid and charities to the State department of health,

TABLE 8.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for services for crippled children under the Social Security Act, title V, part 2, fiscal year ended June 30, 1937*

State[1]	Federal funds available for payment of half the total expenditures under approved State plans					Federal funds budgeted in State plans as approved	Payment
	Total	Balance available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937 [3]				
			Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration		
Total	$3,527,675.98	$678,615.47	[4] $2,849,060.51	$1,020,000	$1,829,060.51	$2,681,350.92	$2,011,606.04
Alabama	70,676.57	13,580.53	57,096.04	20,000	37,096.04	45,091.21	37,442.61
Alaska	28,915.51	8,252.28	20,663.23	20,000	663.23	3,500.00	2,115.62
Arizona	35,328.18	9,855.78	25,472.40	20,000	5,472.40	34,461.00	21,662.74
Arkansas	64,210.46	18,878.95	45,331.51	20,000	25,331.51		
California	100,799.08	28,982.46	71,816.62	20,000	51,816.62	88,920.57	33,731.23
Colorado	61,698.04	12,435.19	49,262.85	20,000	29,262.85	61,500.00	48,794.60
Connecticut	53,476.46	15,723.11	37,753.35	20,000	17,753.35		
Delaware	31,956.98	9,396.31	22,560.67	20,000	2,560.67		
District of Columbia	34,216.74	10,060.69	24,156.05	20,000	4,156.05	25,000.00	663.32
Florida	57,500.00	6.01	57,493.99	20,000	37,493.99	57,500.00	57,494.66
Georgia	85,412.32	25,112.37	60,299.95	20,000	40,299.95	4,993.75	4,993.75
Hawaii	35,436.56	10,419.32	25,017.24	20,000	5,017.24	19,724.16	15,816.03
Idaho	34,642.70	8,975.82	25,666.88	20,000	5,666.88	30,124.84	18,216.52
Illinois	141,239.94	41,525.89	99,714.05	20,000	79,714.05	112,880.00	4,900.00
Indiana	78,349.38	23,035.84	55,313.54	20,000	35,313.54	68,500.00	26,411.65
Iowa	67,390.97	19,814.03	47,576.94	20,000	27,576.94	58,776.94	58,776.94
Kansas	48,998.96	7,539.74	41,459.22	20,000	21,459.22	36,810.00	36,810.00
Kentucky	83,620.26	1,309.39	82,310.87	20,000	62,310.87	83,310.87	82,267.04
Louisiana	67,469.13	19,837.01	47,632.12	20,000	27,632.12		
Maine	40,000.00	6,295.36	33,704.64	20,000	13,704.64	40,000.00	25,465.72
Maryland	54,022.09	15,883.53	38,138.56	20,000	18,138.56	39,000.00	36,033.56
Massachusetts	84,676.00	15,953.47	68,722.53	20,000	48,722.53	84,676.00	61,591.71
Michigan	100,284.49	284.49	100,000.00	20,000	80,000.00	100,284.48	99,999.99
Minnesota	95,161.00	6,163.01	88,997.99	20,000	68,997.99	95,161.00	95,161.00
Missippi	65,997.05	18,035.27	47,961.78	20,000	27,961.78	15,246.89	12,606.40
Missouri	67,970.44	8,684.17	59,286.27	20,000	39,286.27	62,314.00	53,629.83
Montana	32,735.95	6,476.47	26,259.48	20,000	6,259.48	22,309.77	18,869.93
Nebraska	59,355.55	23,191.63	36,163.92	20,000	16,163.92	46,163.92	16,552.38
Nevada	29,555.22	8,690.18	20,865.04	20,000	865.04		
New Hampshire	35,262.65	10,368.19	24,894.46	20,000	4,894.46	4,000.00	2,500.00
New Jersey	115,715.35	21,210.11	94,505.24	20,000	74,505.24	115,715.35	86,711.66
New Mexico	33,244.00	6,530.45	26,713.55	20,000	6,713.55	33,244.00	27,089.28
New York	180,160.50	33,104.00	147,056.50	20,000	127,056.50	103,942.72	74,162.72
North Carolina	98,118.00	18,554.72	79,563.28	20,000	59,563.28	98,118.00	72,789.71
North Dakota	41,393.19	12,170.59	29,222.60	20,000	9,222.60	11,728.44	11,728.44
Ohio	164,120.80	5,419.04	158,701.76	20,000	138,701.76	164,120.80	158,701.76
Oklahoma	61,825.00	20.90	61,804.10	20,000	41,804.10	61,825.00	61,825.00
Oregon	41,787.84	12,286.62	29,501.22	20,000	9,501.22		
Pennsylvania	189,243.24	55,639.03	133,604.21	20,000	113,604.21	189,243.21	106,609.05
Rhode Island	37,703.91	10,092.32	27,611.59	20,000	7,611.59	6,592.62	5,000.00
South Carolina	57,251.74	10,973.29	46,278.45	20,000	26,278.45	37,863.00	37,863.00
South Dakota	40,005.28	11,229.20	28,776.08	20,000	8,776.08	40,005.28	26,551.77
Tennessee	76,026.55	21,772.63	54,253.92	20,000	34,253.92	63,104.42	21,947.75
Texas	152,730.02		152,730.02	20,000	132,730.02	152,730.02	152,717.75
Utah	37,720.31	10,764.72	26,955.59	20,000	6,955.59	37,038.19	29,999.99
Vermont	31,082.46	7,104.23	23,978.23	20,000	3,978.23	16,000.00	12,217.40
Virginia	77,550.00	4,252.75	73,297.25	20,000	53,297.25	77,550.00	73,297.33
Washington	67,196.47	12,123.98	55,072.49	20,000	35,072.49	67,196.47	43,923.40
West Virginia	83,672.00	1,924.03	81,747.97	20,000	61,747.97	83,672.00	80,330.10
Wisconsin	62,350.65	8,903.45	53,447.20	20,000	33,447.20	58,412.00	49,508.55
Wyomihg	32,419.99	9,772.92	22,647.07	20,000	2,647.07	23,000.00	6,124.15

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[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

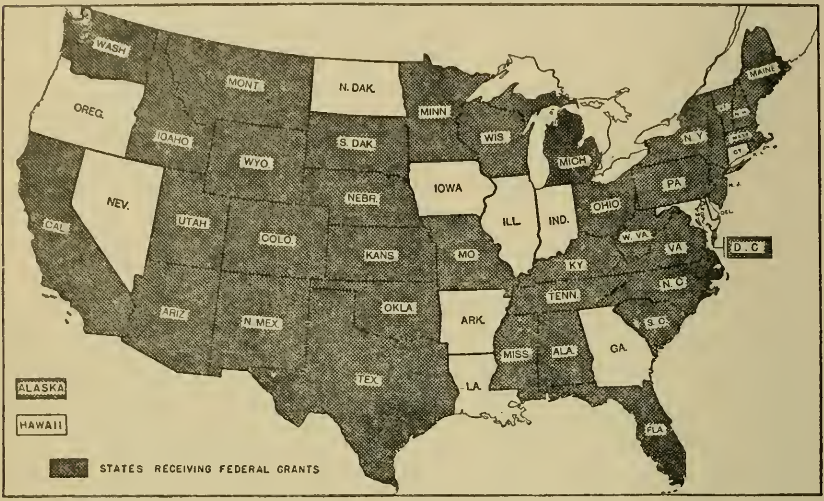
[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

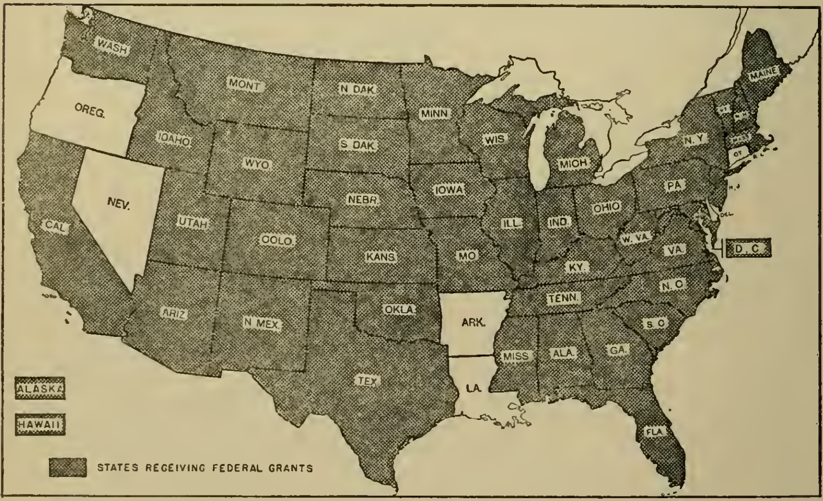
[4] Of $2,850,000 authorized for allotment, $939.49 was not allotted.

Figure 2.—*Services for crippled children; States receiving Federal grants as authorized by the Social Security Act, title V, part 2, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937



and in Tennessee the State commission for crippled children's service was placed under the supervision of the State department of public health. In Arizona, Washington, and West Virginia new departments of public welfare, public assistance, or social security were created, which took over the functions of the old departments of welfare, including services for crippled children. Summary of State plans in operation June 1, 1937, showed the program administered in 19 States by the department of health; in 13, by the department of welfare; in 7, by a crippled children's commission; in 4, by the department of education; in 1, by a university hospital; and in 1, by an interdepartmental committee.[1]

Of the total amount of funds for services for crippled children budgeted in the State plans, 44 percent were State public funds, 15 percent were local public funds, 1 percent was private funds made fully available for public use, and 40 percent were Federal funds (see table 9).

In several States laws passed in 1937 defined more clearly the responsibilities of the State agency for services for crippled children.

Thirty-six States have sent in preliminary reports showing the number of crippled children on the State register, and the number of crippled children thus registered totaled nearly 100,000 on June 30, 1937. Other States planned to report after the names on their registers had been compared with names on other records. The Children's Bureau has prepared an outline for recording the types of crippling conditions, based on the Standard Classified Nomenclature of Disease.[2] The use of this outline by the State agencies should contribute to the obtaining of more definite and comparable information on the incidence of the various types of crippling conditions. A form for use in the State registration of crippled children is being prepared and will be issued for optional use in the States.

The State plans for the fiscal year 1937 and preliminary reports show an increase in the total number of diagnostic clinics held and in the number of such clinics held in areas not previously served, and

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[1] Laws have been enacted, which will be in effect by July 1, 1937, authorizing transfer of the responsibility for services for crippled children as follows: Georgia, responsibility transferred from State department of public health to State department of public welfare; Montana, State orthopedic commission abolished and responsibility transferred to State department of public welfare; South Dakota, responsibility transferred from State public-welfare commission to State board of health.

In the six States whose plans had not been approved by June 1, 1937, the crippled children's agency has been designated as follows: Connecticut, Delaware, Louisiana, Nevada, State department of health; Arkansas and Oregon, State department of public welfare.

[2] Standard Classified Nomenclature of Disease. Edited by H. B. Logie, M. D. Commonwealth Fund, New York, 1935. 870 pp.

TABLE 9.—*Estimated expenditure for services for crippled children under the Social Security Act, title V, part 2, as shown in budgets included in approved State plans for the fiscal year ended June 30, 1937*

State [1]	Total estimated expenditures	State and local funds								Federal funds	
		Total		State public		Local public		Private funds in public treasury			
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$6,597,286.68	$3,954,376.15	60	$2,908,420.45	44	$988,477.22	15	$57,478.48	1	$2,642,910.53	40
Alabama	90,182.42	45,091.21	50	19,774.90	22	1,250.00	1	24,066.31	27	45,091.21	50
Alaska	7,000.00	3,500.00	50	3,500.00	50					3,500.00	50
Arizona	68,923.00	34,462.00	50	34,462.00	50					34,461.00	50
California	171,292.14	85,646.07	50	9,266.07	5	76,380.00	45			85,646.07	50
Colorado	123,000.00	61,500.00	50	61,500.00	50					61,500.00	50
District of Columbia	50,000.00	25,000.00	50	25,000.00	50					25,000.00	50
Florida	140,000.00	90,000.00	64	90,000.00	64					50,000.00	36
Georgia [2]	9,987.50	4,993.75	50	993.75	10			4,000.00	40	4,993.75	50
Hawaii	39,448.33	19,724.17	50	19,724.17	50					19,724.16	50
Idaho	60,443.59	30,318.75	50	30,318.75	50					30,124.84	50
Illinois	225,760.00	112,880.00	50	112,880.00	50					112,880.00	50
Indiana	150,349.15	81,849.15	54	8,000.00	5	73,849.15	49			68,500.00	46
Iowa	146,274.23	87,497.29	60	87,497.29	60					58,776.94	40
Kansas	313,310.76	276,500.76	88	5,000.00	2	271,500.76	87			36,810.00	12
Kentucky	166,621.74	83,310.87	50	83,310.87	50					83,310.87	50
Maine	80,000.00	40,000.00	50	40,000.00	50					40,000.00	50
Maryland	78,000.00	39,000.00	50	39,000.00	50					39,000.00	50
Massachusetts	169,588.00	84,912.00	50	84,912.00	50					84,676.00	50
Michigan	200,568.96	100,284.48	50	100,284.48	50					100,284.48	50
Minnesota	298,456.00	208,295.00	70	208,295.00	70					90,161.00	30
Mississippi	29,250.00	14,625.00	50	5,000.00	17			9,625.00	33	14,625.00	50
Missouri	118,628.00	59,814.00	50	59,814.00	50					59,814.00	50
Montana	46,919.57	24,609.80	52	24,609.80	52					22,309.77	48
Nebraska	93,038.72	46,874.80	50	46,874.80	50					46,163.92	50
New Hampshire	8,000.00	4,000.00	50	4,000.00	50					4,000.00	50
New Jersey	237,705.35	121,990.00	51	20,000.00	8	97,550.00	41	4,440.00	2	115,715.35	49
New Mexico	60,000.00	30,000.00	50	30,000.00	50					30,000.00	50
New York	388,662.72	284,720.00	73	284,720.00	73					103,942.72	27
North Carolina	200,855.00	105,737.00	53	103,732.00	52	2,005.00	1			95,118.00	47
North Dakota [3]	23,456.88	11,728.44	50	11,728.44	50					11,728.44	50

Ohio	740,894.80	581,774.00	79	224,100.00	30	357,074.00	48	600.00	(4)	159,120.80	21
Oklahoma	200,825.00	144,000.00	72	144,000.00	72					56,825.00	28
Pennsylvania	424,043.21	234,800.00	55	234,800.00	55					189,243.21	45
Rhode Island	13,185.24	6,592.62	50	6,592.62	50					6,592.62	50
South Carolina	75,726.00	37,863.00	50	20,000.00	26	13,863.00	18	4,000.00	5	37,863.00	50
South Dakota	80,118.08	40,112.80	50	39,365.63	49			747.17	1	40,005.28	50
Tennessee	126,208.84	63,104.42	50	31,099.11	25	32,005.31	25			63,104.42	50
Texas	305,460.12	152,730.10	50	152,730.10	50					152,730.02	50
Utah	74,076.39	37,038.20	50	37,038.20	50					37,038.19	50
Vermont	32,000.00	16,000.00	50	16,000.00	50					16,000.00	50
Virginia	148,500.00	74,250.00	50	64,250.00	43			10,000.00	7	74,250.00	50
Washington	134,392.94	67,196.47	50	67,196.47	50					67,196.47	50
West Virginia	170,742.00	87,070.00	51	87,070.00	51					83,672.00	49
Wisconsin	228,392.00	169,980.00	74	106,980.00	47	63,000.00	28			58,412.00	26
Wyoming	46,000.00	23,000.00	50	23,000.00	50					23,000.00	50

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[1] The term "State," includes Alaska, Hawaii, and the District of Columbia.

[2] Estimate for 3 months.

[3] Estimate for 9 months.

[4] Less than 1 percent.

indicate effort to provide services on a State-wide basis. There is a tendency for clinics to be used not only for diagnostic service but also for reexamination of children needing continued medical supervision and for certain treatments such as physical therapy, application of casts, and adjustment of braces.

Additional State, Federal, and private funds were made available in Tennessee, Mississippi, Virginia, and Alabama, in the summer and fall of 1936, by means of which immediate examination and treatment could be given to children who were stricken during the poliomyelitis epidemic. These special projects were organized to provide as quickly as possible special diagnostic services, physical therapy, and nursing care for these children. Orthopedic surgeons examined the children, and public-health nurses with physical-therapy training visited them in their own homes to carry out the instructions of the surgeon. Hospitalization was provided for special cases that could not be treated in the child's own home. Appliances were provided by the official State agency. These projects demonstrate the value of immediate diagnosis and treatment in the prevention of crippling following poliomyelitis. During the epidemic the United States Public Health Service conducted a demonstration of preventive measures in these areas.

Current reports continue to show that the majority of children accepted for care by the State agencies are those needing orthopedic or plastic surgery or physical therapy. More complete figures on the number of children affected by each type of crippling condition are needed before policies can be formulated in regard to increase or decrease in services.

The recommendations of the advisory committee on services for crippled children and of the State and Territorial health officers have been of great value to the State agencies in establishing and maintaining adequate standards for medical and hospital care. During the year there has been a decided increase in the number of hospitals approved by official agencies, with a resulting decentralization of hospital care. The approval of hospitals located in different parts of the State makes it possible to provide hospital service nearer the child's own home.

Hospital charges have been under continuous review by the State agencies during the year, and revisions in charges have been made in the light of experience. It has been possible in many instances to arrange, in a manner acceptable to the professional groups involved, for payment on a flat-rate basis, to cover the cost of all hospital services except surgeons' fees and the cost of appliances. Further revisions will undoubtedly be made as longer experience shows more clearly the factors involved, such as the types of cases referred for treatment, the actual cost of ward care, and the financial responsibility assumed by the hospital.

The Children's Bureau has started a study of the admission procedures and discharge policies of hospitals and institutions where crippled children are given convalescent care, which will provide information to be used in later studies.

Charges involving payments for professional services are also undergoing continuous study and revision by the State agencies in consultation with technical advisory groups. In adjusting such charges consideration is given on the one hand to the types of cases referred for treatment, the responsibility involved, and the requirements as to professional certification, and on the other hand to the State's responsibility for the efficient administration of limited public funds intended to provide care for large numbers of crippled children whose parents cannot afford to pay for needed services.

The recommendations of the advisory committee on services for crippled children and of the State and Territorial health officers have also been of great value in the organization of the State agencies and in the selection of qualified staff. The necessity for medical direction is increasingly recognized as indispensable for the development of a well-balanced program and for the safeguarding of the quality of service to be given. When the State agency is not directed by a physician, the need for providing active medical assistance on the technical phases of the program is evident.

Administrative officials realize that the conduct of these services requires technically qualified persons—the physician, the orthopedic surgeon, the nurse, the medical social worker, and the physical therapist. With a wide variety of administrative agencies, it has been interesting to see the methods by which effective working relationships are established among the different types of workers in the program. As the State plans have been put into practice during the year and as services have been extended, the role of each type of worker in the program has become more clearly defined.

The year's experience has also clarified the relationship of the social-security program to the programs of other agencies and organizations engaged in services for crippled children.

State agencies are recognizing that local services are extended most satisfactorily through a system by which maximum advantage is taken of the services of local public-health nurses and local social workers. The State crippled children's agencies are offering such local workers consultation service and staff education through State and district workers with special orthopedic training. The local workers throughout the State thereby become better equipped to give service to crippled children before and after surgical and hospital care.

A system of reporting the services rendered to crippled children, and the number of such children on State registers was put into operation for the quarter July 1 to September 30, 1936. (See p. 41.)

The fact that some States had had no central reporting system and that the program of services was being rapidly extended made it difficult to get complete data at the start. Reports so far sent in indicate that there will be available in the near future more reliable information concerning the numbers of crippled children and the services being provided for their care than has ever previously been assembled in the United States.

In certain States the State agency was able to report during this period only on the services for crippled children for which it was administratively responsible. If services provided in close relationship with the State program but not administered by the State agency had been included (as is being done to an increasing extent through cooperative reporting arrangements) a much larger volume of service would have been shown than in these first reports from the States.

The Children's Bureau advisory committee on services for crippled children held its second meeting with the Children's Bureau October 9 and 10, 1936.

This committee recommended that children whose chief disability is incurable blindness, deafness, or mental defect or whose abnormalities require permanent custodial care should be considered beyond the scope of the program.

With regard to administration the committee recommended (1) that the program should be extended to all persons up to 21 years of age who are found to be in need of such service and who are unable to obtain it otherwise (where statutory provision to include all crippled children up to 21 years of age is necessary, the committee urged that action be taken), (2) that after the first year of operation each official State agency should have on its staff at least a full-time administrator with proper clerical assistance, and (3) that agreements should be worked out between States to insure the use of public funds for the care of crippled children regardless of the duration of their residence in a State.

With regard to professional standards the committee recommended (1) that State agencies should use orthopedic surgeons and other specialists certified by the national boards conducting examinations for certification in the respective specialties, (2) that standards recommended for physical therapists and medical social workers by their respective national organizations should be used, and (3) that the National Organization for Public Health Nursing should be requested to submit recommendations for qualifications for nurses taking part in the program.

The committee submitted minimum standards for hospital care of crippled children and suggested that the State agencies endeavor to obtain from each hospital a flat rate to include all necessary services with the exception of surgeons' fees and appliances.

At its third meeting, April 7, 1937, the advisory committee on services for crippled children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties that confront State agencies in obtaining competent personnel for sparsely settled areas. The committee recommended that the State agencies in reporting crippling conditions use the classification of types of crippling prepared by the Children's Bureau (see p. 83). The committee reviewed and approved the preliminary studies made by the Children's Bureau concerning fee schedules, hospital rates, and other charges, and made suggestions as to future studies.

Child-Welfare Services.

For the fiscal year ended June 30, 1937, State plans for child-welfare services were approved for 44 States and the District of Columbia. (For States receiving grants see fig. 3 and table 10.)[3]

Progress reports received from the States as of December 31, 1936, showed that Federal funds for child-welfare services were providing all or part of the salaries of 170 professional and 47 clerical workers on State welfare department staffs and of 242 social workers and 9 clerical workers assigned to local demonstration units or to districts in which some case-work service was being given under direct State supervision.

One hundred and twenty-two counties in 21 States had 124 child-welfare workers working directly under local boards or welfare officials. In 11 other States 67 workers under State supervision had been assigned to 106 counties. In 3 New England States, 7 workers had been placed in 6 rural areas including 111 towns. In areas where local work was in process of organization, 44 State workers were doing some case work in 370 counties as a part of the process of developing local child-welfare programs.

As a result of the Federal-State program, therefore, services were being rendered to children in 598 counties and in 6 rural New England areas, or in approximately one-fifth of the counties of the United States. The areas selected were all predominantly rural.

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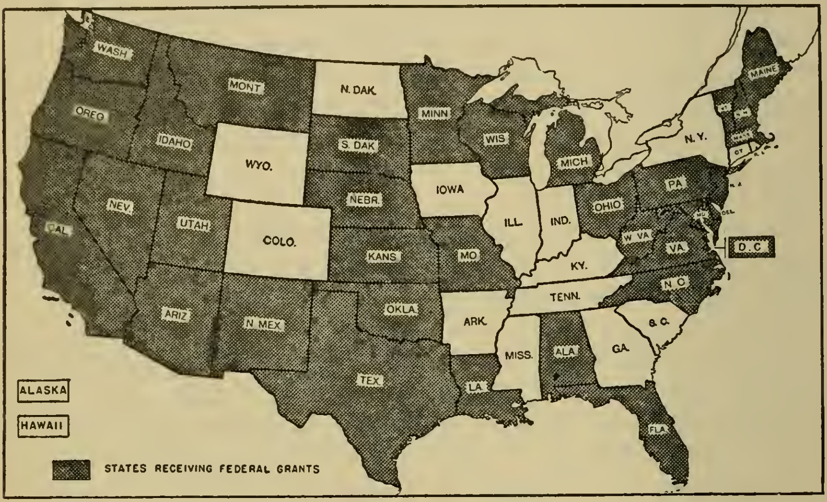
[3] Six States and Territories did not receive Federal grants for child-welfare services in either 1936 or 1937. Under the Social Security Act the following amounts are available annually to these States when State plans for child-welfare services have been developed and approved.

State or Territory	Total	Uniform allotment	Allotment on basis of ratio of rural population of State to total rural population
Alaska	$10, 942. 31	$10, 000	$942. 31
Hawaii	13, 121. 55	10, 000	3, 121. 55
Mississippi	40, 610. 62	10, 000	30, 610. 62
Rhode Island	10, 953. 84	10, 000	953. 84
South Carolina	35, 054. 71	10, 000	25, 054. 71
Wyoming	12, 848. 03	10, 000	2. 848. 03

Figure 3.—*Child-welfare services; States receiving Federal grants as authorized by the Social Security Act, title V, part 3, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937

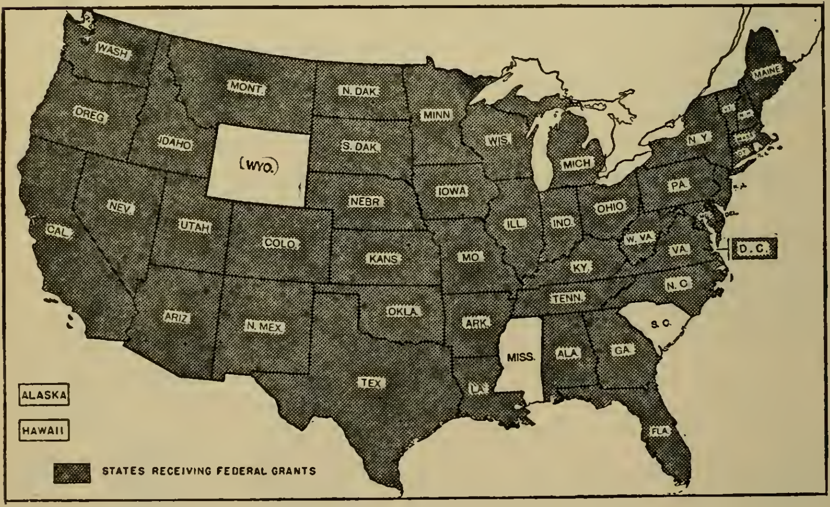


TABLE 10.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for child-welfare services under the Social Security Act, title V, part 3, fiscal year ended June 30, 1937*

State [1]	Federal funds available for payment of part of cost of local services and for development of State services					Federal funds budgeted in State plans as approved	Payment
	Total	Balance available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937 [3]				
			Total	Uniform allotment	Allotment on basis of ratio of rural population in State to total rural population		
Total	$1,899,485.82	$323, 028. 86	[4]$1,376,456.96	$450, 000. 00	$926, 456. 96	$1,534,780.15	$969, 827. 23
Alabama	55, 526. 94	10, 684. 53	44, 842. 41	10, 000. 00	34, 842. 41	55, 490. 00	41, 850. 32
Arizona	19, 905. 83	4, 671. 76	15, 234. 07	10, 000. 00	5, 234. 07	18, 789. 28	5, 404. 82
Arkansas	36, 958. 41	-----------	36, 958. 41	10, 000. 00	26, 958. 41	36, 958. 41	9, 311. 64
California	53, 526. 91	15, 743. 21	37, 783. 70	10, 000. 00	27, 783. 70	43, 520. 00	18, 140. 41
Colorado	19, 450. 97	-----------	19, 450. 97	10, 000. 00	9, 450. 97	19, 450. 97	12, 974. 46
Connecticut	18, 703. 99	-----------	18, 703. 99	10, 000. 00	8, 703. 99	18, 703. 99	10, 291. 26
Delaware	16, 817. 22	4, 706. 24	12, 110. 98	10, 000. 00	2, 110. 98	12, 110. 98	8, 720. 85
Dist. of Columbia	14, 166. 67	4, 166. 67	10, 000. 00	10, 000. 00	-----------	10, 000. 00	5, 582. 28
Florida	31, 873. 60	8, 895. 77	22, 977. 83	10, 000. 00	12, 977. 83	30, 620. 00	17, 857. 15
Georgia	46, 876. 53	-----------	46, 876. 63	10, 000. 00	36, 876. 53	46, 876. 53	33, 569. 94
Idaho	18, 644. 37	2, 864. 24	15, 780. 13	10, 000. 00	5, 780. 13	18, 023. 14	15, 884. 96
Illinois	46, 545. 00	-----------	46, 545. 00	10, 000. 00	36, 545. 00	46, 545. 00	21, 620. 26
Indiana	36, 427. 29	-----------	36, 427. 29	10, 000. 00	26, 427. 29	36, 427. 29	21, 192. 36
Iowa	37, 325. 57	-----------	37, 325. 57	10, 000. 00	27, 325. 57	37, 325. 57	23, 293. 86
Kansas	39, 243. 84	8, 155. 57	31, 088. 27	10, 000. 00	21, 088. 27	39, 243. 80	28, 251. 02
Kentucky	43, 259. 42	-----------	43, 259. 42	10, 000. 00	33, 259. 42	43, 259. 42	30, 270. 92
Louisiana	46, 233. 77	13, 004. 08	33, 229. 69	10, 000. 00	23, 229. 69	46, 233. 77	35, 840. 19
Maine	25, 883. 13	7, 164. 77	18, 718. 36	10, 000. 00	8, 718. 36	20, 072. 00	13, 719. 56
Maryland	30, 479. 06	8, 449. 72	22, 029. 34	10, 000. 00	12, 029. 34	22, 940. 00	16, 333. 17
Massachusetts	24, 299. 46	6, 638. 65	17, 660. 81	10, 000. 00	7, 660. 81	20, 320. 30	10, 174. 55
Michigan	51, 235. 70	13, 019. 76	38, 215. 94	10, 000. 00	28, 215. 94	45, 325. 00	23, 950. 99
Minnesota	44, 128. 45	10, 197. 58	33, 930. 87	10, 000. 00	23, 930. 87	42, 592. 00	29, 489. 92
Missouri	55, 638. 93	13, 209. 64	42, 429. 29	10, 000. 00	32, 429. 29	55, 638. 93	43, 301. 64
Montana	23, 055. 83	6, 523. 80	16, 532. 03	10, 000. 00	6, 532. 03	23, 055. 83	16, 072. 95
Nebraska	36, 612. 12	10, 274. 15	26, 337. 97	10, 000. 00	16, 337. 97	33, 490. 82	17, 216. 41
Nevada	15, 592. 39	4, 555. 64	11, 036. 75	10, 000. 00	1, 036. 75	15, 200. 00	13, 131. 44
New Hampshire	15, 280. 13	1, 758. 95	13, 521. 18	10, 000. 00	3, 521. 18	15, 280. 13	13, 868. 59
New Jersey	32, 082. 31	9, 220. 68	22, 861. 63	10, 000. 00	12, 861. 63	26, 620. 00	15, 622. 41
New Mexico	16, 407. 77	609. 77	15, 798. 00	10, 000. 00	5, 798. 00	16, 407. 77	13, 243. 62
New York	47, 849. 27	-----------	47, 849. 27	10, 000. 00	37, 849. 27	8, 790. 58	8, 790. 58
North Carolina	72, 122. 96	18, 882. 11	53, 240. 85	10, 000. 00	43, 240. 85	62, 681. 00	39, 597. 04
North Dakota	20, 385. 00	-----------	20, 385. 00	10, 000. 00	10, 385. 00	20, 385. 00	15, 963. 62
Ohio	69, 572. 22	20, 381. 77	49, 190. 45	10, 000. 00	39, 190. 45	54, 560. 00	23, 643. 52
Oklahoma	54, 079. 99	15, 239. 00	38, 840. 79	10, 000. 00	28, 840. 79	50, 937. 49	24, 398. 76
Oregon	26, 187. 88	7, 687. 11	18, 500. 77	10, 000. 00	8, 500. 77	26, 187. 88	13, 716. 41
Pennsylvania	93, 404. 03	26, 654. 52	66, 749. 51	10, 000. 00	56, 749. 51	92, 690. 03	35, 162. 64
South Dakota	26, 424. 39	6, 130. 14	20, 294. 25	10, 000. 00	10, 294. 25	23, 040. 00	20, 325. 80
Tennessee	41, 509. 13	-----------	41, 509. 13	10, 000. 00	31, 509. 13	28, 438. 75	28, 438. 75
Texas	98, 462. 80	25, 530. 09	72, 932. 71	10, 000. 00	62, 932. 71	90, 758. 45	42, 438. 21
Utah	17, 406. 76	2, 981. 18	14, 425. 58	10, 000. 00	5, 425. 58	17, 197. 50	14, 665. 36
Vermont	18, 963. 16	4, 551. 11	14, 412. 05	10, 000. 00	4, 412. 05	18, 850. 00	15, 305. 42
Virginia	52, 608. 10	12, 632. 36	39, 975. 74	10, 000. 00	29, 975. 74	43, 338. 50	32, 566. 67
Washington	23, 747. 04	1, 311. 02	22, 436. 02	10, 000. 00	12, 436. 02	23, 747. 04	22, 484. 36
West Virginia	39, 926. 54	7, 253. 02	32, 673. 52	10, 000. 00	22, 673. 52	38, 805. 00	28, 437. 24
Wisconsin	44, 654. 94	9, 280. 05	35, 374. 89	10, 000. 00	25, 374. 89	37, 852. 00	37, 710. 92

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[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

[4] Of $1,500,000 available for allotment, $123,543.04 was not allotted.

The State plans for child-welfare services for the fiscal year ending June 30, 1937, included, on the whole, the objectives set up in the first set of State plans for the fiscal year 1936. Based on the situation in each State, these plans, which were formulated by the Children's Bureau and the State public-welfare agencies, were directed toward better standards of service to children.

Although it was not possible to obtain enough State and local workers with special training and experience in the child-welfare field to fill all the new positions created, the State agencies in the majority of cases were able to employ persons who had had either training or experience or both in some phase of social work. Frequent popular insistence on the employment of legal residents of the State restricted the selection of workers on the basis of qualifications. The limited training and experience of the workers employed in the child-welfare field made apparent the need for budgeting some of the Federal funds for training purposes. Provision for training under the State plans includes: (1) Educational leave to enable qualified personnel to attend schools of social work, (2) training on the job through intensive supervision, (3) a few training centers where students work under a supervisor, and (4) institutes to orient workers in child welfare.

The scope of the child-welfare services made available has been appreciably broadened in the local areas where the demonstration units have been located. The following excerpt from a progress report gives an account of typical services provided:

> In one district, of 150 children referred for attention during a 6-month period, family adjustments were made for 32 children; health care was arranged for 28; material assistance was obtained for 30; the aid of relatives was enlisted for 11; 6 were placed in local foster homes; 2 were placed in a children's home; and plans are still in process for 54 children.
>
> Of 327 children referred in another district, family and school adjustments were worked out for 195 children; health care arranged for 28; material assistance obtained for 115; aid of relatives enlisted for 24; 6 were placed in local foster homes; and 106 children remain under continuing supervision.
>
> In a third district, of 40 children referred, family adjustments were made for 7 children; 10 were given health care; material assistance was obtained for 6; care by relatives was arranged for 8; 1 was placed in a local foster home; and 6 were placed in a children's home. Plans for 22 children were still in process of development at the time of reporting.

There is a definite trend toward a generalized service by public-welfare workers, State and local, which has affected plans for child-welfare services. In some States a portion of the Federal funds for child-welfare services is used to pay part of the salaries of field staff workers doing general public-welfare work as well as child-welfare work.

Reports from the State agencies show that the local child-welfare workers are utilizing all available social resources, public and private.

One of the first tasks of a worker going into a rural community is to determine the availability of resources. In many places services offered by organizations in metropolitan centers never reach rural communities, even though the program of the organization is supposed to include nonurban regions.

Some of the first cases reported to local workers are those involving feeble-minded children. The depression years shifted attention and funds away from the care of the feeble-minded. As services for children become available in rural communities, there should be renewed interest in securing facilities for the care of the feeble-minded. The reports clearly indicate the many demands for medical care and corrective treatment. In spite of efforts of the child-welfare workers to search out all resources, many of these needs cannot be met at present.

Many of the States include in their plans for rural child-welfare services some provision for psychologic and psychiatric services. In some instances it has been made evident that without basic social services these more specialized skills cannot be used effectively.

Demonstration services for Negro children were included in the original plans submitted by North Carolina and Alabama, and these have been continued. In the Florida training center there is a Negro worker. The Kentucky State Home for Colored Children is included in the special institution project incorporated in the Kentucky plan. A Negro worker has been added to the Delaware staff.

No State submitted an official plan involving the use of Federal funds for services which had formerly been financed by the State itself. The Children's Bureau has consistently held to the principle that the Federal funds granted to a State are for services which otherwise would not be provided and that in no case are they to be used in order to enable a State to conserve its own funds. In a number of States, however, the amount of Federal funds for child-welfare services is in excess of the amount of State funds thus far appropriated for child-welfare work.

Appendix 1.—Text of the Sections of the Social Security Act Relating to Grants to States for Maternal and Child Welfare

Title V.--GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

Part 1.—MATERNAL AND CHILD HEALTH SERVICES

APPROPRIATION

Section 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $3,800,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 502. (*a*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and such part of $1,800,000 as he finds that the number of live births in such State bore to the total number of live births in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(*b*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to the States $980,000 (in addition to the allotments made under subsection (*a*)) according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of live births in such State.

(c) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 504 until the end of the second succeeding fiscal year. No payment to a State under section 504 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 503. (*a*) A State plan for maternal and child-health services must (1) provide for financial participation by the State; (2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State health agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for the extension and improvement of local maternal and child-health services administered by local child-health units; (6) provide for cooperation with medical, nursing, and welfare groups and organizations; and (7) provide for the development of demonstration services in needy areas and among groups in special need.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State health agency of his approval.

PAYMENT TO STATES

Sec. 504. (*a*) From the sums appropriated therefor and the allotments available under section 502 (*a*), the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

> (1) The Secretary of Labor shall, prior to the beginning of each quarter estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.
>
> (2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.
>
> (3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(*c*) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 502 (*b*), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

OPERATION OF STATE PLANS

Sec. 505. In the case of any State plan for maternal and child-health services which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 503 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 2.—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

Sec. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $2,850,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 512. (*a*) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

(*b*) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 513. (*a*) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for carrying out the purposes specified in section 511; and (6) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

Sec. 514. (*a*) From the sums appropriated therefor and the allotments available under section 512, the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

OPERATION OF STATE PLANS

Sec. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 3.—CHILD-WELFARE SERVICES

Sec. 521. (*a*) For the purpose of enabling the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, public-welfare services (hereinafter in this section referred to as "child-welfare services") for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $1,500,000. Such amount shall be allotted by the Secretary of Labor for use by cooperating State public-welfare agencies on the basis of plans developed jointly by the State agency and the Children's Bureau, to each State, $10,000, and the remainder to each State on the basis of such plans, not to exceed such part of the remainder as the rural population of such State bears to the total rural population of the United States. The amount so allotted shall be expended for payment of part of the cost of district, county, or other local child-welfare services in areas predominantly rural, and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need. The amount of any allotment to a State under this section for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under this section until the end of the second succeeding fiscal year. No payment to a State under this section shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

(*b*) From the sums appropriated therefor and the allotments available under subsection (*a*) the Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States, and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

* * * * * * *

Part 5.—ADMINISTRATION

Sec. 541. (*a*) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of $425,000, for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531.

(*b*) The Children's Bureau shall make such studies and investigations as will promote the efficient administration of this title, except section 531.

(*c*) The Secretary of Labor shall include in his annual report to Congress a full account of the administration of this title, except section 531.

* * * * * * *

Title XI.—GENERAL PROVISIONS

DEFINITIONS

Section 1101. (*a*) When used in this Act—

(1) The term "State" (except when used in section 531) includes Alaska, Hawaii, and the District of Columbia.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

* * * * * * *

(*d*) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS

Sec. 1102. The Secretary of the Treasury, the Secretary of Labor, and the Social Security Board, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

SEPARABILITY

Sec. 1103. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act, and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

Sec. 1104. The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

Sec. 1105. This Act may be cited as the "Social Security Act."

Appendix 2.—State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937

STATE	Maternal and Child-Health Services Title V, Part 1	Services for Crippled Children Title V, Part 2	Child-Welfare Services Title V, Part 3
ALABAMA	*State Department of Public Health*, James N. Baker, M. D., State Health Officer. Bureau of Hygiene and Nursing, B. F. Austin, M. D., Director.	*State Department of Education*, J. A. Keller, Superintendent. Division of Vocational Education, J. B. Hobdy, Director.	*State Department of Public Welfare*, A. H. Collins, Commissioner. Mrs. Harry Simon, Administrative Assistant. Bureau of Child Welfare, Mrs. Judith Hall Gresham, Director.
ALASKA	*Territorial Department of Health*, W. W. Council, M. D., Commissioner. Division for Maternal and Child Health and Crippled Children, Sonia Cheifetz, M. D., Director.	Division for Maternal and Child Health and Crippled Children, Sonia Cheifetz, M. D., Director.	
ARIZONA	*State Board of Health*, Coit Hughes, M. D. Division of Maternal and Child Health, Jack B. Eason, M. D., Director.	*State Board of Social Security and Public Welfare*, Lee Garrett, Commissioner. Division for Crippled Children, Ruth E. Wendell, Director.	Ann M. Bracken, Director of Social Service.
ARKANSAS	*State Board of Health*, W. B. Grayson, M. D., State Health Officer. Maternal and Child Health Division, W. Myers Smith, M. D., Director.		*State Department of Public Welfare*, Gussie Haynie, Commissioner. Mrs. Ruth Moore Cline, Acting Supervisor, Child-Welfare Services.
CALIFORNIA	*State Department of Public Health*, W. M. Dickie, M. D., Director. Bureau of Child Hygiene, Ellen S. Stadtmuller, M. D., Chief.	Bureau of Administration, W. M. Dickie, M. D., Director.	*State Department of Social Welfare*, Mrs. Florence L. Turner, Director. Social Security Program, O. C. Wyman, Administrator. Division of Child-Welfare Services, Miley M. Pope.
COLORADO	*State Division of Public Health*, R. L. Cleere, M. D., Secretary and Executive Officer. Division of Maternal and Child Health, Vera H. Jones, M. D., Director.	Division of Crippled Children, Vera H. Jones, M. D., Director.	*State Department of Public Welfare*, Earl M. Kouns, Director. Child Welfare Division, Marie C. Smith, Director.
CONNECTICUT	*State Department of Health*, Stanley H. Osborn, M. D., Commissioner of Health. Bureau of Child Hygiene, Martha L. Clifford, M. D., Director.		*State Public Welfare Council*, F. C. Walcott, Commissioner. Bureau of Child Welfare, Grace M. Houghton, Director of Child Care. Mrs. Mary Buckley, Supervisor, Child-Welfare Services.

DELAWARE	*State Board of Health*, A. C. Jost, M. D., Executive Secretary. Division of Maternal and Child Health, Woodbridge E. Morris, M. D., Director.	----------	*State Board of Charities*, Charles L. Candee, President. Elsie Lee Spring, Associate Secretary.
DISTRICT OF COLUMBIA	*Health Department of the District of Columbia*, George C. Ruhland, M. D., Health Officer. Bureau of Maternal and Child Welfare, Ella Oppenheimer, M. D., Director.	*Board of Public Welfare*, Elwood Street, Director.	
		Division of Care for Crippled Children, Paul L. Kirby, Chief.[1]	Division of Child Welfare, A. Patricia Morss, Director. A. Madorah Donahue, in charge of Child-Welfare Services.
FLORIDA	*State Board of Health*, W. A. McPhaul, M. D., State Health Officer. Bureau of Maternal and Child Health (Director to be appointed).	*Crippled Children's Commission*, O. G. Kendrick, M. D., Chairman.	*State Board of Social Welfare*, Conrad Van Hyning, Commissioner. Department of Child Welfare, Mrs. Ruth W. Atkinson, Director. Louise K. Carr, Technical Consultant, Child-Welfare Services.[2]
GEORGIA	*State Department of Public Health*, T. F. Abercombie, M. D., Director. Division of Child Hygiene, Joe P. Bowdoin, M. D., Chief.	*State Department of Public Welfare*, Lamar Murdaugh, Director.	
			Division of Child Welfare, Frances Steele, Director. Loretto Chappell, Supervisor, Child-Welfare Services.
HAWAII	*Territorial Board of Health*, F. E. Trotter, M. D., Territorial Commissioner of Public Health.		
	Bureau of Maternal and Infant Hygiene, Fred K. Lam, M. D., Director.	Division of Services to Crippled Children, Bureau of Maternal and Infant Hygiene, Fred K. Lam, M. D., Director.	
IDAHO	*State Department of Public Welfare*, the Hon. Barzilla W. Clark, Governor of the State, Commissioner of Public Welfare ex officio.		*State Department of Public Assistance*. Peter H. Cohn, Director, Louise Cuddy, Child-Welfare Supervisor.
	James W. Hawkins, M. D., Director of Division of Public Health. Bureau of Maternal and Child Health and Crippled Children.	James W. Hawkins, M. D., Director of Division of Public Health. Bureau of Maternal and Child Health and Crippled Children, G. D.	
ILLINOIS	*State Department of Public Health*, Frank J. Jirka, M. D., Director. Division of Child Hygiene and Public-Health Nursing, Grace S. Wightman, M. D., Chief.	*State Department of Public Welfare*, A. L. Bowen, Director.	
		Crippled Children's Division, Paul H. Harmon, Director.	Division of Child Welfare, Edna Zimmerman, Superintendent of Child Welfare. Ruth M. Bartlett, Supervisor, Child-Welfare Services.

[1] Responsibility for administering services for crippled children was transferred to the Health Department of the District of Columbia July 1, 1937.

[2] Responsibility for administering child-welfare services was transferred to the State welfare board July 1 ,1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

<table>
<tr><th>STATE</th><th>Maternal and Child-Health Services Title V, Part 1</th><th>Services for Crippled Children Title V, Part 2</th><th>Child-Welfare Services Title V, Part 3</th></tr>
<tr><td>INDIANA</td><td><i>State Board of Health</i>, Verne K. Harvey, M. D., Director.
Bureau of Maternal and Child Health, Howard B. Mettel, M. D., Director.</td><td><i>State Department of Public Welfare</i>, Services to Crippled Children, Oliver W. Greer, M. D., Director.</td><td>Thurman A. Gottschalk, Administrator.
Children's Division, Mildred Arnold, Director. Louise Griffin, Supervisor, Child-Welfare Services.</td></tr>
<tr><td>IOWA</td><td><i>State Department of Health</i>, Walter L. Bierring, M. D., Commissioner of Health.
Division of Child Health and Health Education, J. H. Kinnaman, M. D., Director.</td><td><i>State Board of Education</i>, W. M. Cobb, Comptroller. Iowa City.
State University of Iowa, E. M. MacEwen, M. D., Dean College of Medicine, Iowa City.</td><td><i>State Board Social Welfare</i>, W. F. Miller, Chairman.
Bureau of Child Welfare, Frank T. Walton, Superintendent. Anneda Slavins, Supervisor, Child-Welfare Services.</td></tr>
<tr><td>KANSAS</td><td><i>State Board of Health</i>, Earle G. Brown, M. D., Secretary and Executive Officer.
Division of Child Hygiene, H. R. Ross, M. D., Director.</td><td><i>Crippled Children Commission</i>, R. A. Raymond, Secretary.</td><td><i>Kansas Emergency Relief Committee</i>, Jerry E. Driscoll, Executive Director. Esther E. Twente, Superintendent of Relief. Emily W. Dinwiddie, Supervisor, Child-Welfare Services. [3]</td></tr>
<tr><td>KENTUCKY</td><td><i>State Department of Health</i>, A. T. McCormack, M. D., State Health Commissioner.
Bureau of Maternal and Child Health. (Director to be appointed.)</td><td><i>Crippled Children Commission</i>, Marian Williamson, Director.</td><td><i>State Department of Welfare</i>, Frederick A. Wallis, Commissioner.
Division of Child Welfare, Mrs. Mabel B. Marks, Director.</td></tr>
<tr><td>LOUISIANA</td><td><i>State Board of Health</i>, J. A. O'Hara, M. D., President.
Division of Maternal and Child Health, L. A. Masterson, M. D., Director.</td><td>------</td><td><i>State Department of Public Welfare</i>, A. R. Johnson, Commissioner.
Bureau of Child Welfare, Mrs. Irene Farnham Conrad, Director.</td></tr>
<tr><td rowspan="2">MAINE</td><td colspan="3"><i>State Department of Health and Welfare</i>, George W. Leadbetter, Commissioner.</td></tr>
<tr><td>Bureau of Health, George H. Coombs, M. D., Director.
Division of Maternal and Child Health and Crippled Children, Herbert R. Kobes, M. D., Director.</td><td>Bureau of Health, George H. Coombs, M. D., Director.
Division of Maternal and Child Health and Crippled Children, Herbert R. Kobes, M. D., Director.</td><td>Bureau of Social Welfare, Norman W. MacDonald, Director. Lena Parrott, Consultant, Child-Welfare Services.</td></tr>
<tr><td rowspan="2">MARYLAND</td><td colspan="2"><i>State Department of Health</i>, R. H. Riley, M. D., Director</td><td rowspan="2"><i>Board of State Aid and Charities</i>, J. Milton Patterson, Executive Secretary.
Social Work Department, Anita J. Faatz, Director.
Child Welfare Division, Mrs. Isabelle K. Carter, Director.</td></tr>
<tr><td>Bureau of Child Hygiene, J. H. Mason Knox, M. D., Chief.</td><td>Services for Crippled Children, C. H. Holliday, M. D., Director.</td></tr>
</table>

MASSACHUSETTS	*State Department of Public Health*, Henry D. Chadwick, M. D., Commissioner of Health. Division of Child Hygiene, M. Luise Diez, M. D., Director.	Division of Administration, Public Health Administration, Orthopedic Unit, Edward G. Huber, M. D., Director.	*State Department of Public Welfare*, Walter V. McCarthy, Commissioner. Division of Child Guardianship, Winifred A. Keneran, Director. Lillian A. Foss, Supervisor, Child-Welfare Services.
MICHIGAN	*State Department of Health*, C. C. Slemons, M. D., Commissioner of Health. Bureau of Child Hygiene and Public Health Nursing, Lillian R. Smith, M. D., Director.	*Crippled Children Commission*, Harry H. Howett, Secretary-Treasurer.	*State Welfare Department*, James G. Bryant, Director. Lansing. Michigan Children's Institute, C. F. Ramsay, Superintendent, Helen F. Geddes, Supervisor, Child-Welfare Services.
MINNESOTA	*State Department of Health*, A. J. Chesley, M. D., Secretary and Executive Officer. Division of Child Hygiene, E. C. Hartley, M. D., Director.	*State Board of Control*, E. C. Carlgren, Chairman. Division of Services for Crippled Children, H. E. Hilleboe, M. D., Director.	Children's Bureau, Charles F. Hall, Director. Jean Johnson, Supervisor, Child-Welfare Services.
MISSISSIPPI	*State Board of Health*, Felix J. Underwood, M. D., Executive Officer.	*State Board for Vocational Education*, J. S. Vandiver, Chairman and Executive Officer. F. J. Hubbard, State Director of Vocational Education.	
MISSOURI	*State Board of Health*, H. S. Parker, M. D., State Health Commissioner. Division of Child Hygiene, James Chapman, M. D., Director.	*University of Missouri*, Leslie Cowan, Secretary. State Crippled Children's Service, William J. Stewart, M. D., Director.	*State Board of Managers of Eleemosynary Institutions*, W. Ed Jameson, President.[4] State Children's Bureau, Carrollton. Mrs. W. W. Henderson, Executive Director. Mary Lois Pyles, Supervisor, Child-Welfare Services.
MONTANA	*State Board of Health*, W. F. Cogswell, M. D., Secretary. Child Welfare Division, Jessie M. Bierman, M. D., Director.	*Montana Orthopedic Commission*, Mrs. P. J. Brophy, Chairman. Freda E. Miller, Executive Secretary.[5]	*State Department of Public Welfare*, I. M. Brandjord, State Administrator. Mrs. Maggie Smith Hathaway, Secretary, State Bureau of Child Protection, Supervisor of Child-Welfare Services.
NEBRASKA	*State Department of Health*, P. H. Bartholomew, M. D., Acting Director of Health. Division of Maternal and Child Health, J. Warren Bell, M. D., Director.	*State Board of Control*, N. C. Vandemoer, Director. Child Welfare Division, Harry Becker, Acting Director.	Child Welfare Division, Harry Becker, Acting Director.
NEVADA	*State Board of Health*, John E. Worden, M. D., State Health Officer. Maternal and Child-Health Division, H. Earl Belnap, M. D., Director.		*State Board of Relief, Work Planning and Pension Control*, Gilbert C. Ross, Secretary. Cecilia Carey, Director, Child-Welfare Services.

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[3] Responsibility for administering child-welfare services was transferred to the State board of social welfare July 1, 1937.

[4] Responsibility for administering child-welfare services was transferred to the State social-security commission June 23, 1937.

[5] Responsibility for administering services for crippled children was transferred to the State department of public welfare July 1, 1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

<table>
<tr><th>STATE</th><th>Maternal and Child-Health Services Title V, Part 1</th><th>Services for Crippled Children Title V, Part 2</th><th>Child-Welfare Services Title V, Part 3</th></tr>
<tr><td rowspan="2">NEW HAMPSHIRE</td><td colspan="2"><i>State Board of Health</i>, Travis P. Burroughs, M. D., Secretary.</td><td rowspan="2"><i>State Board of Welfare and Relief</i>, Division of Welfare, Jay H. Corliss, Director. Charlotte Leeper, Supervisor, Social Security Services.</td></tr>
<tr><td>Division of Maternity, Infancy, and Child Hygiene, Byron H. Farrall, M. D., Director.</td><td>Division of Maternity, Infancy, and Child Hygiene, Byron H. Farrall, M. D., Director.</td></tr>
<tr><td>NEW JERSEY</td><td><i>State Department of Health</i>, J. Lynn Mahaffey, M. D., Director of Health.
Bureau of Child Hygiene, Julius Levy, M. D., Consultant.</td><td><i>Crippled Children's Commission</i>, Joseph G. Buch, Chairman-Director.</td><td><i>State Department of Institutions and Agencies</i>, William J. Ellis, Commissioner.
Board of Children's Guardians, Joseph E. Alloway, Executive, Director. Minnie Kuhfuss, Supervisor, Child-Welfare Services.</td></tr>
<tr><td rowspan="2">NEW MEXICO</td><td rowspan="2"><i>State Department of Public Health</i>, E. B. Godfrey, M. D., Director.
Division of Maternal and Child Health, Hester Curtis, M. D., Director.</td><td colspan="2"><i>State Department of Public Welfare</i>, Fay Guthrie, Director. Mrs. Laura Waggoner, Director of Social Service.</td></tr>
<tr><td>Crippled Children's Division</td><td>Child Welfare Division.</td></tr>
<tr><td rowspan="2">NEW YORK</td><td colspan="2"><i>State Department of Health</i>, Edward S. Godfrey, M. D., State Commissioner of Health</td><td rowspan="2"><i>State Department of Social Welfare</i>. David C. Adie, Commissioner.
Bureau of Child Welfare, Grace A. Reeder, Director.</td></tr>
<tr><td>Division of Maternity, Infancy, and Child Hygiene, Elizabeth M. Gardiner, M. D., Director.</td><td>Division of Orthopedics, Walter J. Craig, M. D., Director.</td></tr>
<tr><td rowspan="2">NORTH CAROLINA</td><td colspan="2"><i>State Board of Health</i>, Carl V. Reynolds, M. D., State Health Officer.</td><td rowspan="2"><i>State Board of Charities and Public Welfare</i>, Mrs. W. T. Bost, Commissioner.
Division of Child Welfare, Lily E. Mitchell, Director. Virginia Denton, Assistant Director for Child-Welfare Services.</td></tr>
<tr><td>Maternal and Child Health Services, G. M. Cooper, M. D., Director.</td><td>Division for Crippled Children, G. M. Cooper, M. D., Medical Director.</td></tr>
<tr><td rowspan="2">NORTH DAKOTA</td><td rowspan="2"><i>Department of Public Health</i>, Maysil M. Williams, M. D., State Health Officer.
Maternal and Child Health Division, August Orr, M. D., Director.</td><td colspan="2"><i>Public Welfare Board of North Dakota</i>, E. A. Willson, Executive Director.</td></tr>
<tr><td>Children's Bureau, Theodora Allen, Supervisor.</td><td>Child Welfare Division, Theodora Allen, Supervisor.</td></tr>
<tr><td rowspan="2">OHIO</td><td rowspan="2"><i>State Department of Health</i>, Walter H. Hartung, M. D., Director of Health.
Bureau of Child Hygiene, P. L. Harris, M. D., Acting Chief.</td><td colspan="2"><i>State Department of Public Welfare</i>.</td></tr>
<tr><td>Division of Charities, Gertrude Fortune, Superintendent. Crippled Children's Bureau, Mabel E. Smith, Chief.</td><td>Division of Charities, Gertrude Fortune, Superintendent. Helen Mawer, Supervisor, Child-Welfare Services.</td></tr>
</table>

OKLAHOMA	*State Department of Public Health*, Charles M. Pearce, M. D., State Health Commissioner. Division of Maternal and Child Health, Paul J. Collopy, M. D., Director.	*Commission for Crippled Children*, Joe N. Hamilton, Executive Secretary.	*State Department of Public Welfare*, Harve L. Melton, Director. Grace Browning, Assistant Director. Laura Dester, Director, Child-Welfare Services.
OREGON	*State Board of Health*, Frederick D. Stricker, M. D., State Health Officer. Maternal and Child Health Division, G. D. Carlyle, M. D., Director.		*State Relief Committee*, Elmer R. Goudy, Administrator. Loa Howard, Social Work Director. Norris E. Class, Supervisor, Child-Welfare Services.
PENNSYLVANIA	*State Department of Health*, Edith MacBride-Dexter, M. D., Secretary of Health.		*State Department of Welfare*, John D. Pennington, Secretary of Welfare. Division of Community Work, Rosemary Reinhold, Chief. Marguerite E. Brown, Supervisor of Rural Extension Unit.
	Bureau of Maternal and Child Health, Wayne S. Ramsey, M. D., Director.	Crippled Children's Service, John S. Donaldson, M. D., Director. State Hospital for Crippled Children.	
RHODE ISLAND	*State Department of Public Health*, Edward A. McLaughlin, M. D., Director		
	Bureau of Child Hygiene, Marion A. Gleason, M. D., Chief.	Crippled Children's Division, William A. Horan, M. D., Director.	
SOUTH CAROLINA	*State Board of Health*, James A. Hayne, M. D., State Health Officer.		
	Division of Maternal and Child Health, R. W. Ball, M. D., Director.	Division of Crippled Children, Mrs. Eunice H. Leonard, Director.	
SOUTH DAKOTA	*State Board of Health*, P. B. Jenkins, M. D., Superintendent of Health. Division of Maternal and Child Health, Viola Russell, M. D., Director.	*State Department of Public Welfare*, Alvin Waggoner, Director.	
		P. B. Jenkins, M. D., Assistant Welfare Commissioner (Superintendent of Health). Division of Crippled Children, G. J. Van Heuvelen, M. D., Director.[6]	Mrs. Ruth Deets, Technical Assistant, Child-Welfare Services. Mrs. Mary Bryan, Executive Secretary, Child Welfare Commission, Supervisor of Child-Welfare Services.[7]
TENNESSEE	*State Department of Public Health*, W. C. Williams, M. D., Commissioner of Public Health.		*State Department of Institutions and Public Welfare*. George H. Cate, Commissioner. Vallie Smith Supervisor, Child-Welfare Services.
	Division of Maternal and Child Health, John M. Saunders, M. D., Director.	Commission for Crippled Children's Service, T. Graham Hall, Chairman. W. J. Breeding, M. D., Medical Director and Supervisor.	
TEXAS	*State Department of Health*, George W. Cox, M. D., State Health Officer. Division of Maternal and Child Health, J. W. E. H. Beck, M. D., Director.	*State Department of Education*, Crippled Children's Division, J. J. Brown, Director, James L. Tenney, Chief.	*State Board of Control*, Claude D. Teer, Chairman. Division of Child Welfare, Mrs. Violet S. Greenhill, Chief. Mrs. Norma Rankin, Director, Child-Welfare Services.

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[6] Responsibility for administering services for crippled children was transferred to the State board of health July 1, 1937.

[7] Responsibility for administering child-welfare services was transferred to the State department of social security July 1, 1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

<table>
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<tr><td rowspan="2">UTAH</td><td colspan="2"><i>State Board of Health</i>, J. L. Jones, M. D., State Health Commissioner.</td><td rowspan="2"><i>State Department of Public Welfare</i>, Darrell J. Greenwell, Director. Social Service Division, Mrs. V. M. Parmelee, Director.</td></tr>
<tr><td>Bureau of Maternal and Child Health, Mildred Nelson, M. D., Director.</td><td>Crippled Children's Service, Marcella McInnerny, R. N., Director.</td></tr>
<tr><td rowspan="2">VERMONT</td><td colspan="2"><i>State Department of Public Health</i>, Charles F. Dalton, M. D., Secretary and Executive Officer</td><td rowspan="2"><i>State Department of Public Welfare</i>, Timothy C. Dale, Commissioner. Mrs. Omeron H. Coolidge, Deputy Commissioner.</td></tr>
<tr><td>Maternal and Child Health Division, Paul D. Clark, M. D., Director.</td><td>Crippled Children's Division, Lillian E. Kron, R. N., Director.</td></tr>
<tr><td rowspan="2">VIRGINIA</td><td colspan="2"><i>State Department of Health</i>, I. C. Riggin, M. D., State Health Commissioner.</td><td rowspan="2"><i>State Department of Public Welfare</i>, Arthur W. James, Commissioner. Children's Bureau, W. L. Painter, Director. Harriet L. Tynes, Supervisor, Child-Welfare Services.</td></tr>
<tr><td>Bureau of Child Health, B. B. Bagby, M. D., Director.</td><td>Crippled Children's Bureau, E. C. Harper, M. D., Director.</td></tr>
<tr><td rowspan="2">WASHINGTON</td><td rowspan="2"><i>State Department of Health</i>, Donald Evans, M. D., Director of Health.
Division of Maternal and Child Hygiene, John D. Fuller, M. D., Director.</td><td colspan="2"><i>State Department of Social Security</i>, Charles F. Ernst, Director.</td></tr>
<tr><td>Division for Children, Mrs. Helen C. Swift, Supervisor.</td><td>Division for Children, Mrs. Helen C. Swift, Supervisor.</td></tr>
<tr><td rowspan="2">WEST VIRGINIA</td><td rowspan="2"><i>State Department of Health</i>, Arthur E. McClue, M. D., State Health Commissioner.
Division of Child Hygiene, Thomas H. Blake, M. D., Director.</td><td colspan="2"><i>State Department of Public Assistance</i>, A. W. Garnett, Director.</td></tr>
<tr><td>Children's Bureau, Francis W. Turner, Chief.
Division of Crippled Children (Supervisor to be appointed.)</td><td>Children's Bureau, Francis W. Turner, Chief.
Division of Child-Welfare Services, Ruth C. Schad, Supervisor.</td></tr>
<tr><td>WISCONSIN</td><td><i>State Board of Health</i>, C. A. Harper, M. D., State Health Officer.
Bureau of Maternal and Child Health, Amy Louise Hunter, M. D., Chief.</td><td><i>Interdepartmental Committee for Crippled Children's Services</i>, R. C. Buerki, M. D., Chairman.
Crippled Children's Division, State Department of Public Instruction, Mrs. Marguerite Lison Ingram, Director.</td><td><i>State Board of Control</i>, John J. Hannan, President.
Juvenile Department, Elizabeth Yerxa, Director.</td></tr>
<tr><td rowspan="2">WYOMING</td><td colspan="2"><i>State Board of Health</i>, G. M. Anderson, M. D., State Health Officer.</td><td rowspan="2"></td></tr>
<tr><td>Division of Maternal and Child Health, Margaret H. Jones, M. D., Director.</td><td>Division for Crippled Children, Margaret H. Jones, M. D., Director.</td></tr>
</table>

Appendix 3.—Members[1] of Advisory Committees Appointed by the Secretary of Labor to Advise With the Children's Bureau Concerning the Development of General Policies Affecting the Administration of Title V, Parts 1, 2, and 3 of the Social Security Act

GENERAL ADVISORY COMMITTEE ON MATERNAL AND CHILD-WELFARE SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; Apr. 7 and 8, 1937]

Chairman, Kenneth D. Blackfan, M. D., Professor of Pediatrics, Harvard University School of Medicine, Boston, Mass.

Grace Abbott, Professor of Public Welfare, School of Social Service Administration, University of Chicago, Chicago, Ill.

Fred L. Adair, M. D., Professor of Obstetrics and Gynecology, University of Chicago School of Medicine, Chicago, Ill.

W. W. Bauer, M. D., Director, Bureau of Health and Public Instruction, American Medical Association, Chicago, Ill.

M. O. Bousfield, M. D., Director, Negro Health Service, Julius Rosenwald Fund, Chicago, Ill.

C. C. Carstens, Executive Director, Child Welfare League of America, New York, N. Y.

John A Ferrell, M. D., Chairman, Executive Board, American Public Health Association,[2] New York, N. Y.

F. H. Fljozdal, President, Brotherhood of Maintenance of Way Employees, Detroit, Mich.

Homer Folks, Secretary, State Charities Aid Association, New York, N. Y.

Amelia H. Grant, R. N., President, National Organization for Public Health Nursing, New York, N. Y.

Clifford G. Grulee, M. D., Secretary and Treasurer, American Academy of Pediatrics; Editor, American Journal of Diseases of Children; Clinical Professor of Pediatrics, Rush Medical College, University of Chicago, Chicago, Ill.

T. Arnold Hill, Director, Department of Industrial Relations, National Urban League, New York, N. Y.

Fred K. Hoehler, Director, American Public Welfare Association, Chicago, Ill.

Arlien Johnson, Director, Graduate School of Social Work, University of Washington, Seattle, Wash.

Paul H. King, President, International Society for Crippled Children, Detroit, Mich.

Blanche L. LaDu, Member, Executive Committee, American Public Welfare Association, Chicago, Ill.

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[1] Each member of these advisory committees was appointed for a 2-year term.

[2] Thomas Parran, Jr., M. D., was appointed as the representative of the American Public Health Association in 1935. Dr. Ferrell was appointed as his successor in 1937.

Mrs. S. Blair Luckie, General Federation of Women's Clubs, Chester, Pa.

The Reverend Bryan J. McEntegart, Director, Division of Children, Catholic Charities, New York, N. Y.

Mrs. George B. Mangold, National League of Women Voters, Los Angeles, Calif.

Mary E. Murphy, Director, Elizabeth McCormick Memorial Fund; National Chairman, Committee on Child Hygiene, National Congress of Parents and Teachers, Chicago, Ill.

Robert B. Osgood, M. D., Emeritus Professor of Orthopedic Surgery, Harvard University Medical School, Boston, Mass.

Abbie C. Sargent, President, The Associated Women of the American Farm Bureau Federation, Bedford, N. H.

Dora H. Stockman, National Grange, East Lansing, Mich.

Mrs. Nathan Straus, National Council of Jewish Women, New York, N. Y.

Linton B. Swift, General Director, Family Welfare Association of America, New York, N. Y.

Douglas A. Thom, M. D., Director, Division of Mental Hygiene, Massachusetts State Department of Mental Diseases; Professor of Psychiatry, Tufts College Medical School, Boston, Mass.

ADVISORY COMMITTEE ON MATERNAL AND CHILD-HEALTH SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; June 5, 1936; Apr. 7 and 8, 1937]

Chairman, Henry F. Helmholz, M. D., Professor of Pediatrics, Mayo Foundation, University of Minnesota Medical School, Rochester, Minn.

Thomas F. Abercrombie, M. D., Director of Public Health, Georgia State Board of Health, Atlanta, Ga.

S. Josephine Baker, M. D., Princeton, N. J.

Ernest A. Branch, D. D. S., Director, Division of Oral Hygiene, State Board of Health, Raleigh, N. C.

Hazel Corbin, R. N., General Director, Maternity Center Association, New York, N. Y.

Robert L. DeNormandie, M. D., Boston, Mass.

George W. Kosmak, M. D., Editor, American Journal of Obstetrics and Gynecology, New York, N. Y.

Elmer V. McCollum, Sc. D., Professor of Biochemistry, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.

Grover F. Powers, M. D., Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.

Oscar Reiss, M. D., Associate Clinical Professor of Medicine (Pediatrics), University of Southern California School of Medicine, Los Angeles, Calif.

Lillian R. Smith, M. D., Director, Bureau of Child Hygiene and Public Health Nursing, Michigan Department of Health, Lansing, Mich.

Elnora E. Thomson, R. N., Director of Nursing Education, University of Oregon Medical School, Portland, Oreg.

Felix J. Underwood, M. D., Secretary and Executive Officer, Mississippi State Board of Health; Chairman of Child-Hygiene Committee of Conference of State and Provincial Health Authorities of North America, Jackson, Miss.

ADVISORY COMMITTEE ON MATERNAL WELFARE

[Appointed 1936]
[Meeting held Mar. 22, 1937]

Chairman, Fred L. Adair, M. D., Professor of Obstetrics and Gynecology, University of Chicago School of Medicine, Chicago, Ill.

Hazel Corbin, R. N., General Director, Maternity Center Association, New York, N. Y.

Robert L. DeNormandie, M. D., Boston, Mass.

George W. Kosmak, M. D., Editor, American Journal of Obstetrics and Gynecology, New York, N. Y.

James R. McCord, M. D., Professor of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Ga.

Lyle G. McNeile, M. D., Professor of Obstetrics and Gynecology, University of California School of Medicine, Los Angeles, Calif.

Alice N. Pickett, M. D., Associate Professor of Obstetrics, University of Louisville School of Medicine, Louisville, Ky.

E. D. Plass, M. D., Professor of Obstetrics and Gynecology, State University of Iowa College of Medicine, Iowa City, Iowa.

Philip F. Williams, M. D., Assistant Professor of Obstetrics, University of Pennsylvania School of Medicine, Philadelphia, Pa.

ADVISORY COMMITTEE ON SERVICES FOR CRIPPLED CHILDREN

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; Oct. 9 and 10, 1936; Apr. 7 and 8, 1937]

Chairman, Albert H. Freiberg, M. D., Professor of Orthopedic Surgery, University of Cincinnati College of Medicine, Cincinnati, Ohio.

George E. Bennett, M. D., Associate Professor of Orthopedic Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

R. C. Buerki, M. D., Superintendent, State of Wisconsin General Hospital, Madison, Wis.

M. Antoinette Cannon, Medical Social Service Department, New York School of Social Work, New York, N. Y.

Bronson Crothers, M. D., Assistant Professor of Pediatrics, Harvard University Medical School, Boston, Mass.

Mildred Elson, Editor, Physiotherapy Review, Chicago, Ill.

Ralph K. Ghormley, M. D., Associate Professor of Orthopedic Surgery, University of Minnesota Graduate School of Medicine, Rochester, Minn.

Harry H. Howett, Secretary-Treasurer, Michigan Crippled Children's Commission, Lansing, Mich.

Bess R. Johnson, Principal, Smouse Opportunity School, Des Moines, Iowa.

T. Duckett Jones, M. D., Research Director, House of the Good Samaritan, Boston, Mass.

J. Albert Key, M. D., Professor of Clinical Orthopedic Surgery, Washington University School of Medicine, St. Louis, Mo.

O. L. Miller, M. D., Consulting Surgeon, North Carolina Orthopedic Hospital, Charlotte, N. C.

Marian Williamson, R. N., Director, Kentucky Crippled Children Commission, Louisville, Ky.

Edith Baker, formerly Director, Social Service Department, Washington University Clinics and Allied Hospitals, St. Louis, Mo., served as a member of the committee until her appointment to the staff of the Children's Bureau, July 27, 1936.

ADVISORY COMMITTEE ON COMMUNITY CHILD-WELFARE SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; June 1 and 2, 1936; April 7 and 8, 1937]

Chairman, H. Ida Curry, Superintendent, County Children's Agencies, State Charities Aid Association, New York, N. Y.

C. W. Areson, Chief Probation Officer, Domestic Relations Court, City of New York, New York, N. Y.

Sophonisba P. Breckinridge, Professor of Public Welfare Administration, School of Social Service Administration, University of Chicago, Chicago, Ill.

Violet S. Greenhill, Chief, Division of Child Welfare, Texas State Board of Control, Austin, Tex.

A. T. Jamison, Superintendent and Treasurer, Connie Maxwell Orphanage, Greenwood, S. C.

Cheney C. Jones, Superintendent, New England Home for Little Wanderers, Boston, Mass.

Rose J. McHugh, Chief, Administrative Surveys Division, Bureau of Public Assistance, Social Security Board, Washington, D. C.

James S. Plant, M. D., Director, Essex County Juvenile Clinic, Newark, N. J.

Emma C. Puschner, Director, National Child Welfare Division, The American Legion, National Headquarters, Indianapolis, Ind.

Alice Leahy Shea, Department of Sociology and Social Work, University of Minnesota, Minneapolis, Minn.

Gay B. Shepperson, Administrator, Works Progress Administration, Atlanta, Ga.

Edwin D. Solenberger, General Secretary, Children's Aid Society of Pennsylvania, Philadelphia, Pa.; President, Child Welfare League of America, Inc., New York, N. Y.

Ruth Taylor, Commissioner of Public Welfare of Westchester County, White Plains, N. Y.

The Rt. Rev. Monsignor R. Marcellus Wagner, Director of Catholic Charities, Cincinnati, Ohio.

J. Prentice Murphy, Executive Secretary, Children's Bureau of Philadelphia, served as a member of the committee until his death, February 1, 1936.

C. V. Williams, Superintendent, Illinois Children's Home and Aid Society, Chicago, Ill., served as a member of the committee until his death, October 9, 1937.

ADVISORY COMMITTEE ON TRAINING AND PERSONNEL IN THE FIELD OF CHILD WELFARE[1]

[Appointed 1936]

[Meetings held: Oct. 19, 1936; May 23, 1937]

Chairman, Walter W. Pettit, Assistant Director, New York School of Social Work, New York, N. Y.

Edith Abbott, Dean, Graduate School of Social Service Administration, University of Chicago, Chicago, Ill.

William W. Burke, Associate Professor and Director of Child Welfare, School of Business and Public Administration, Washington University, St. Louis, Mo.

M. Antoinette Cannon, Medical Social Service Department, New York School of Social Work, New York, N. Y.

E. N. Clopper, in Charge of Graduate Training for Public Service, University of Cincinnati, Cincinnati, Ohio.

Arthur Dunham, Professor of Community Organization, Institute of Health and Social Science, University of Michigan, Detroit, Mich.

Gordon Hamilton, Instructor in Family Case Work, New York School of Social Work, New York, N. Y.

Kenneth Pray, Director, Pennsylvania School of Social and Health Work, Philadelphia, Pa.

Christine C. Robb, Assistant Executive Secretary, American Association of Social Workers, New York, N. Y.

Alice Leahy Shea, Department of Sociology and Social Work, University of Minnesota, Minneapolis, Minn.

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[1] This committee also serves the Social Security Board.

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Proceedings of the Conference on State Child-Welfare Services

Social Security Act, August 14, 1935
Title V, Part 3

Washington, D. C.
April 4–6, 1938

Maternal and Child-Welfare Bulletin No. 3

Children's Bureau
United States Department of Labor

UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, Secretary
CHILDREN'S BUREAU—Katharine F. Lenroot, Chief

Proceedings of the Conference on State Child-Welfare Services

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JAN 20 1939

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Letter of Transmittal

United States Department of Labor,
Children's Bureau,
Washington, August 1, 1938.

Madam: There is transmitted herewith a report of the conference on State child-welfare services under the Social Security Act, which met at Washington, D. C., from April 4 to April 6, 1938. The proceedings of the conference have been prepared for publication by the staff of the Child Welfare Division of the Children's Bureau.

Respectfully submitted.

Katharine F. Lenroot, *Chief.*

Hon. Frances Perkins,
Secretary of Labor.

Proceedings of the Conference on State Child-Welfare Services (Social Security Act, August 14, 1935, Title V, Part 3), Washington, D. C., April 4–6, 1938

Monday, April 4—Morning Session

H. Ida Curry, Chairman, United States Children's Bureau Advisory Committee on Community Child-Welfare Services, Presiding

The Chairman. I am sure you are all quite as thrilled as I am that we are getting together once more to review what has been done in child-welfare work in rural areas. I do not believe that any of you realize the significance of this meeting as Mr. Carstens and I do. Our minds run back 20 years to a time when there was practically no rural social work under any auspices, except in a very few spots in the United States. What has occurred in these last 2 years has been due largely to the leadership of the Children's Bureau. It is a great pleasure to have at the head of that Children's Bureau as understanding a woman as the one who presides over it, and I am very much pleased to present to you Miss Katharine F. Lenroot.

Miss Lenroot. So many of our contacts have to be made through correspondence and verbal reports from our field staff. We could not go on at the Children's Bureau, those of us who have to be at desks most of the time, if we did not have occasional opportunities to work with you in person, sometimes out in the field, when it is a rare privilege of mine to see you in your own habitats, and more often in the conferences here.

We are very happy in the privilege of having the Secretary of Labor with us.

We should never forget that the social-security program of which you are a part grew out of the work of the Cabinet Committee on Economic Security, of which Miss Perkins was chairman. Her realization of the breadth of a social-security program and of the necessity of making work for children the heart of the program, led to the opportunities that you have for service.

The Secretary of Labor. I cannot tell you how glad I am to be here and how welcome you are in Washington under the roof of the Department of Labor for this conference.

It is a great pleasure also to know that we are going to have, for a few days at least, conferences with people who have reality always before them when they speak; for we who are here in Washington are without the stimulus of the people who face the problem realistically in the field. We are apt to grow theoretical. We are bound to do that if we sit and read reports. We are bound to compare one report with another and then come to some kind of logical conclusion as to what they all mean.

The thing that I have learned as I have gone through life has been that logic is a wonderful thing. It is a great invention of mankind. It is a system that man invented to help him think with the use of these cumbersome tools that we call words. If we had not had to use words to help our thinking process we probably should never have gone far with thought. Having invented words we had to invent logic to help us think with words. But though people have learned to think logically they do not always act logically, and it is in action that the really important part of life lies. It is what people do and not how they are able to think that matters. People who sit and read reports are likely to follow a logical process of thought and come to a logical conclusion if it is not corrected by the people who work in the field with human beings, who see them day after day, not acting and reacting logically but acting and reacting according to some inner needs and pressures—some God-given aspiration, some power of self-discipline that logically they ought not to have, some hopefulness that logically they could not possibly have. If one has not seen them doing that sort of thing one is likely to come to a false program. That is why it is so reviving to us to have direct contact with you who are in the field, who are seeing people, who know intimately those who are faced with the very problems for which we are today making meager but honest provision. It is this meager and honest provision which we Americans should take to our hearts, not so much regretting that it is meager as rejoicing that it is at least an honest and honorable attempt, in which all of us are involved, to make life worth living and to make life as good as possible for the people who happen to be living upon this part of the continent at this particular time in the history of civilization.

The keynote of this whole conference appears to be that we are coming to realize that a program that is suitable and possible in one community with one set of problems and one set of capabilities on the part of its people—a program that can be utilized successfully in that community—is not necessarily the same program that can be utilized successfully in another community. The very key to our understanding of what we ought to do is an honest but personal approach to the problems of community activity, recognizing that we must be and our program must be adaptable above everything else, and that it is after all the sincerity and honesty of heart and purpose with which the workers approach their particular problems that make them likely to have success.

So I hope the time will never come when we here in Washington write a ticket, so to speak, and send it to you through the mails and require you to act exactly along the lines laid down in the specifications. It is the essence of honest work for people and with people that they themselves—the people who are the victims or the subjects or the beneficiaries of the activity, whatever you want to call them—should be able to take part in it and contribute to it as well as those who are doing the work. I was delighted to hear this note and to realize, from what Miss Lenroot has told me of what is going on, that this is really the refreshing and reviving point of view which you are bringing to this whole program, which is based upon the idea that the Federal Government and the States and the local citizens everywhere can participate in working out programs following the same general principles but utilizing in every community the things that are best known and best adapted to the people of that community.

Thank you so much for letting me come in for even a little while. I shall hope to see more of you while you are here in Washington.

Philosophy and Development of Federal-State Relationships

By Katharine F. Lenroot, *Chief, Children's Bureau, United States Department of Labor*

This conference of State directors and supervisors of child-welfare services gives all of us a real thrill, as we realize what has been done in a period of 2 years in translating into reality the purposes which were in the minds of all those who had some share in the development of title V, part 3, of the Social Security Act.

It was not 2 years ago that the first conference of State supervisors of child-welfare services was held in Washington, in June 1936, immediately following the National Conference of Social Work in Atlantic City. At that time an appropriation had been available for only 4 months and plans were just in the process of development. I know that people in the States as well as the people in the Children's Bureau sometimes got a little jittery wondering just how, with the relatively small amounts of money provided in the act, the very general purposes of the appropriation expressed in the act could be carried out.

In those first months, in conference with staff and with the people in the States, it was emphasized that the objective of Federal-aid programs, as administered through the years in various forms of service and as conceived by those responsible for all the titles of the Social Security Act, was to help to meet needs of people in every State and in every community and to stimulate the development of certain Nation-wide standards. These standards are based on recognition of the fact that the needs of children and families and communities everywhere are really the same but that the way they are met must vary from State to State and from community to community, in accordance with particular conditions and with the general framework of the economic, social, and political organization within which the people of the community and the State live. So in the Children's Bureau we approached, on a case-work basis, the problem of joint planning with the States, as the act requires. I think I can perhaps brag a little, for I feel that we are very fortunate in having in the Child Welfare Division, as director, assistant director, and field representatives, people who are thoroughly steeped in the philosophy of the case-work approach and of not trying to develop a priori theories from Washington to be applied regardless of local situations or methods of organization but of working out the problems as you work out a case-work problem with a family or an individual.

In the development of the social-security program it was recognized, of course, that we were just at the threshold of enlarging our concepts of what constitutes a broad welfare program on a State-wide basis that will serve the needs of rural as well as urban communities. For a generation or more, perhaps two generations, the leaders in the development of urban social work had recognized the fact that people need help for a variety of reasons—economic, medical, and other reasons—and that resources should be available to meet all these types of needs. That concept was basic in the charity-organization movement and the family-welfare movement, but on the whole it had not gotten into our State services nor into the services available outside the large cities. Moreover, the emphasis that had to be given during the period of depression to the vast and overwhelming economic needs of the people, the needs for relief and assistance, had more or less overshadowed other needs for social-welfare service.

Provision of funds for child-welfare services, very limited in amount, only a drop in the bucket in comparison to social needs, was, nevertheless, a recognition of this other type of problem, of this other approach on the basis of consideration of individual needs that might arise from a variety of reasons only partly economic, although the very important factor of the economic situation is in almost every type of need.

Therefore, child-welfare funds were made available on a broad basis and were directed particularly toward strengthening local services, because it was realized that this broader concept of a welfare program must be developed in the local community where needs emerge and where they may be dealt with at very early stages of development.

The aid, of course, was not intended to represent, nor was it in such amounts that it could represent, a real participation of the Federal Government in a completely rounded State program of welfare. In the first place we had to specify, on recommendation of our advisory committee, although it was not in the law, that funds could not be used for the maintenance of children in foster homes or institutions, because the fund would not stretch that far. Also, it was obvious that funds could not be used for such important programs of State service as the care of delinquent children, the care of feeble-minded children, and the care of children with physical handicaps, except to the extent that the use of a small amount of money for study or demonstration of the relationship between these large State programs and the program of community services might help to bring into closer relationship all the aspects of a complete welfare program.

Many States at the beginning of the social-security program did not have anything approaching a developed State child-welfare program or even a State program of public welfare, so that, as the reports for the 6 months ending December 31, 1937, show in no inconsiderable number of instances, the programs being carried on with child-welfare money, and perhaps in major part with Federal funds, do represent practically all the services, apart from institutional care, that are being developed on a State-wide basis to meet the needs of dependent, neglected, and delinquent children and children in danger of becoming delinquent.

The fact that the legislature will be meeting in the next year in practically every State and that the programs have been in operation now for nearly 2 years means that all of you, in preparing for next year's activities, will want to analyze very carefully the whole broad range of welfare services for families and for children; to consider the extent to which the State is meeting its responsibilities for children, the extent to which it may be possible in the near future to strengthen its services, extend them, and put into the program increasing proportions of State funds. All of us who have had experience in the rural programs know that we cannot make effective throughout the States the minimum essentials of service unless State funds as well as local funds are utilized.

It may be that as the program develops there will emerge in this field, as in other fields, the need for threefold sharing—Federal, State, and local—to equalize opportunities and help support services as well as to demonstrate methods in newer fields. The child-welfare-services program essentially is one of demonstration. None of us knows what future developments will bring, but we do know that the next step in many States is to consider very seriously the broad outlines of a State welfare program and the extent to which the State may contribute more effectively in terms not only of money but also of leadership.

I am deeply gratified by the evidences of real achievement that we have in the progress reports and in the accounts that come to us of the work that you are doing and the pioneer spirit with which you and your staffs are attacking these problems.

I do want to mention some allied considerations that you will wish to keep in mind to fill in the outlines of the picture that you may get in your brief visit to Washington. We hope it is not going to be altogether a period of work and that you will take time to see something of the beauties of Washington. But I want you to see Washington in terms of the various ways in which people here are trying to think through some of the problems of economic and social life.

As you know, we have in the Children's Bureau, to begin here at home, research activities going on, and services in the fields of maternal and child health and work for crippled children that are intimately related to your own child-welfare-services programs.

To begin with the field of social service, the Social Service Division, of which Miss Hanna is director, has been paying special attention during the past year to problems of adoption and illegitimacy, problems that I know come up again and again in your own work and in your consultation service to local communities.

The Delinquency Division, of which Miss Castendyck is director, is making studies of institutional care of delinquent children and has an advisory committee which had an all-day meeting Friday. Mr. McLaughlin, the chairman, is with us this morning. On this advisory committee some of the superintendents of boys' and girls' schools, associated with representatives of two or three other fields of activity, are giving very serious consideration to the problems of the training schools and the ways in which they may make their services more effective and more closely related to the community activities which the child-welfare services are fostering. In a number of States we have had collaboration in the programs of service for delinquent children and the child-welfare services, through intake and population studies and through assistance, on a demonstration basis, in developing case-work services in institutions.

Then we have in a small area in St. Paul a demonstration of methods of preventing and dealing with delinquency before the stage when it must have judicial or correctional-school treatment. We are just now trying to get into that program some skilled group-work service that will approach problems of children from the combined point of view of the case worker and the group worker, applying some of the things that have been developed in a pioneer way in Chicago, Cleveland, and other places. The child-welfare-services programs in rural areas include work which is similar to the activities in this urban demonstration, and I hope that in the months to come there can be perhaps some work in one or two rural areas that will directly relate to the things that we are trying to accomplish in the city area.

In maternal and child-health work under the Social Security Act all the States, Alaska, Hawaii, and the District of Columbia are cooperating with us. We have been giving special consideration to the gaps in the program—the things which must be attacked next if we are really to save maternal life and the lives of newborn babies in this country. I am sure you know that at the January conference nearly 500 representatives of 86 national organizations met here in Washington for 2 days to consider in a very broad way the whole program of maternal mortality and maternal care and the care of newborn babies. The direct relation of this program to your program is indicated by the fact that each year about 35,000 children are left motherless because of the deaths of their mothers from causes associated with pregnancy and childbirth.

The crippled children's program is in operation in every State but one. I have been very much pleased to see in the progress reports for State after State evidence that you and those in charge of crippled children's programs are really getting together to make available to the crippled child in a concrete way the assistance that his needs require.

The program of aid to dependent children is being carried on by the Social Security Board and must be thought of in the very closest relationship to this program. I know that when we raise problems of how far a program of service to dependent children, neglected children, and delinquent children should be extended, we cannot escape consideration of the relative stage of development of aid to dependent children and the great needs in that field for carrying the program forward on a basis of increasing adequacy. The problems of relief, of course, and the ways in which the State and local communities are meeting these problems, are uppermost in all our minds.

This year the problems of medical care loom large in all your work, I know, and I am sure you will be interested, if you do not already know about it, in the report of the Interdepartmental Committee to Coordinate Health and Welfare Activities, which has just been issued, on the need for a national health program. A technical committee, representing the Children's Bureau, the Public Health Service, and the Social Security Board, worked for about 8 months in exploring the problem and was responsible for the preparation and submission of this report to the full interdepartmental committee, which accepted it and transmitted it to the President. The Committee considered the needs of children for medical care, as well as the needs of mothers and newborn infants, and pointed out the absolute necessity of developing services on a State-wide and a Nation-wide basis to meet the needs of children who cannot otherwise receive the medical care and health supervision necessary to keep them in a condition of full health and vitality.

The educational program, of course, is also closely related to the child-welfare-services program, and again and again I have been pleased to see, in the progress reports, appreciation of this fact and evidences of cooperation with the schools. I want to call your attention to a report of the Advisory Committee on Education, which has just been transmitted to the President and to Congress, reviewing the general problems of education and the relation of the Federal Government to general elementary and secondary education and special problems of education such as vocational education.

These are some of the things that I should like to have you keep in mind and be thinking of as you go back to your own States, because this program is going to fail unless it continues to perform the service which I know has been performed so well during the past 2 years, namely, bringing to light hitherto unknown and neglected needs of children and helping communities to view them in relation to the total community picture and to develop more adequate ways of meeting them. The remark that Miss Lathrop made years ago that the juvenile court helped to make the child visible is applicable to the child-welfare-services program.

I am so happy that we can have with us in these deliberations and that we are to hear at dinner tonight from Dr. Plant, whose book, "Personality and the Cultural Pattern," has so much of stimulus suggestion, and challenge for all social workers. All of us, I am sure, are realizing more and more, as we sense more keenly the problems of the world around us, that personality is the supremely important thing and that if American civilization is to mean anything to the world that meaning must lie in the extent to which we cherish and nurture and cultivate the personality of our people.

The CHAIRMAN. We have been fortunate to have so dynamic a person as a leader in the development of this rural work; one also who by reason of her past experience had already a wide knowledge of the conditions in different States of the Union, and we are glad now to hear from Miss Mary Irene Atkinson, Director of the Child Welfare Division of the Children's Bureau.

Miss ATKINSON. Miss Lenroot has referred to the differences that exist in the child-welfare-services programs developed jointly by the Children's Bureau and the State welfare agencies. I do not know who wrote title V, part 3, of the Social Security Act, but whoever is responsible for the wording certainly injected into that part of the act a great deal of flexibility, which has made it possible to work with the States on a case-work basis.

In planning the program for this meeting we have deliberately chosen to place the accent on content. Each of you may have some questions about administrative procedure and legislation. We shall be very glad to discuss these questions with you individually, but we should like to carry through these 3 days of conference on the basis of a very definite underscoring of what this program is about in terms of its effect upon children.

We have asked the people from the States rather than the staff of the Child Welfare Division to participate in this program. After this morning those of us on the staff of the Children's Bureau are, we hope, going to be seen and not heard. It is your conference and we want it to be as informal as possible.

We could not ask all the States to participate in the formal presentation of material. We tried to choose from sections of the country that would be fairly representative, and I am sure that the contributions of the various States will vary greatly.

The CHAIRMAN. And now we are going to find out what child-welfare services have meant in some of the States. One of the States that until recently could not be called upon to discuss what was going on in the social-welfare field is going to be represented this morning by a speaker who will tell us what Nevada is accomplishing. I am delighted to introduce Miss Cecilia Carey, who is director of the service in Nevada.

What Child-Welfare Services Have Meant From the Point of View of the State

By Cecilia Carey, *Director, Child-Welfare Services, Nevada*

Nevada, probably more than any other State in the Union, can really tell what child-welfare services have meant, and the reason is that they have meant everything from the point of view of welfare to the State as a whole. At the present time we can say very honestly that without the stimulus that was given by child-welfare services provided through the Social Security Act, we probably would not be so far along today in Nevada as we are. This was due to the fact that at the inception of our program there was no State-wide social-work agency in existence. There was no State welfare department at all. All the problems of people who were in need were handled either through a Federal work-relief program or through counties. By the time Nevada got around to creating a welfare department, a child-welfare-services program had already been in existence for 9 months. We had grown from a staff of three trained workers to a staff of six trained workers. We had demonstrated not only that was there a need for social work in a State that had not previously thought there was, but that a staff of trained social workers could really handle the job and do it successfully. Perhaps the latter achievement is the greater one. Our emphasis on high personnel standards and a staff-training program has made itself felt in the State welfare department that has now been created.

In addition to providing the nucleus for the new department, the child-welfare-services program has provided the beginnings of sound social work involving children and taking care of children's needs and has made considerable headway in bringing to light the weaknesses of the State and in making plans for and leading the way toward overcoming these weaknesses.

Our influence has been felt as strongly as it has been during the past 2 years partly because Nevada was really a virgin field so far as social work was concerned. In order to know some of the things we encountered in developing our program it would be, perhaps, a good thing for you to picture this State, which is certainly different from any other State in the Union.

Nevada has an area of 110,000 square miles, only 540 square miles of which are under cultivation. The rest of it consists of vast desert wastes and grazing lands; not rolling hills, but mountainous, bush-covered grazing lands that are very little different from the desert wastes except that there is some contribution in them.

The total population of the State is only 110,000. Reno, the largest city in the State, has 20,000 people. The population of the other 12 or 15 urban communities ranges from 10,000 down to a very few hundred. In many places people live 100 miles from the nearest doctor or neighbor, and not along good highways either. It has been nothing to us in the State to travel 100 or 150 miles in going from one place to another without seeing another person or passing another traveler.

In the absence of a State welfare agency the child-welfare-services program was attached to the State board of relief, work, planning, and pension control created in 1935 to receive Federal grants-in-aid. This board was given very broad powers. It handled the work-relief-program funds and did planning throughout the State, and its powers were general enough so that it was thought justifiable to allow it to administer the child-welfare-services program. The only working organization of the board at the time we began was the Works Progress Administration. The child-welfare-services agency began its life in a little office that was donated to it by the W. P. A., and everything that we had in services, office equipment, and the other things we needed came to us through that agency. A survey of resources made it clear that Nevada was a very "have not" State from the point of view of child welfare and general welfare. We learned early that if we were going to have development that was very real and very pertinent we would have to be an independent organization.

Among the immediately evident resources was the Nevada State Orphanage, governed by an ex officio board of three members and operated under the direction of a superintendent. Intake was limited to children received on court commitment, and the institution was in a deplorable state. You might like to hear how bad it was, and then I will tell you how much better it became. The building was in a run-down condition so far as physical equipment goes. One boys' dormitory had been closed because the heating plant was so inefficient that the rooms could not be heated at all. One of the toilet rooms for the boys was locked because the plumbing was very bad. The youngsters ate from tin dishes in a cheerless dining room. The boys were on one side and the girls on the other side. They were lined up to march in. No conversation was permitted. Staff members, who had their own meals in a separate dining room, were stationed around the walls of the room to enforce silence and discipline. The superintendent placed children for adoption at his discretion. No records or investigations were known and very little was known about the children themselves, even their birth dates being sometimes lacking. The compiling of information of that sort was initiated after we began to do some work there.

Besides the State orphanage we had the Nevada Industrial School, which cared for boys committed by the courts as juvenile delinquents. Girls committed to that institution were transferred to training schools outside the State. This institution was under much better management than the orphanage, but it was still true that boys and girls were released from there with no plans for aftercare.

In the absence of a State welfare organization, general relief and aid to mothers in the State were handled by each of the 20 counties. Three counties employed workers; not trained workers but for the most part persons who seemed to need a job and who handled all the relief problems of the county. The other 17 counties did all their work through their county commissioners. There were two full-time probation officers in the State and one half-time probation officer. None of the three had any special equipment for the work.

Because of the neighborly condition the State was still in, we could secure for a child anything that was needed if we could find a worthy ancestor anywhere in the child's background; any plan could be financed if there was "worthiness." But the problem of money was a very real one. We began to be afraid that it might do us very little good to know that foster-home care was indicated, or that a mother's relief grant should be increased, or that a child needed special training, if it meant always that we had to go to the county commissioners as the only source of funds. In addition to having to go to counties for money every time we needed any, there was also the problem of taxes in the State. The sources from which funds may be derived in our State are quite limited. Our boast, you know, is "One Sound State"; no sales tax, no income tax, and no inheritance tax. The railroads and public utilities furnish about 55 percent of the revenue that is collected. The rest comes from taxes on bullion, property taxes, gasoline tax, and revenue from the sale of liquor. There is, in addition, a constitutional tax limitation of $5 per hundred dollars valuation in the State. In many places we have already reached that $5 limitation, and almost every other place in the State is very close to it.

Within a short time we became conscious of another problem, that of juvenile-court procedure. We saw many cases handled by juvenile-court judges, who were the regular district-court judges, in which all people who were interested were sworn in as witnesses and were made to testify for or against, in the presence of all parties concerned. We still see that in some places, but in other places we have done much better and that sort of thing does not go on any longer.

Another problem that faced us very early in our history was the lack of facilities for giving health care or care for specific groups. That is, we had no State provision for the care of tuberculosis and none for the care of feeble-minded children. Feeble-minded children were a charge on the county, if they were provided for at all, and there was no local provision for the care of tuberculosis.

Public-health nurses in the State went into the field under the maternal and child-health program at about the same time we did, and while the two services have now built up much better resources through cooperative efforts, in the early stages each of us had very little to contribute to the other.

The school situation was another hurdle for us. Recalling the description I have given of the State, you will not be surprised to know that in many places it is not possible to have a high school or to have one available for all children who are interested in going to one. Our laws require that we provide every child with an eighth-grade education, but the existence of high schools themselves is left to the individual school district; if the high-school population is sufficient, high schools can be had, if there is money for them.

Overshadowing all these physical handicaps was the complete ignorance throughout the State of what social work means and what a child-welfare program could mean and was going to mean. The general attitude in our completely rural State was "well, that is all right for your city slums, you need that sort of thing there, but we haven't those problems and we take very good care of our people without all that fuss," and social workers themselves were not any too well thought of in the State. So it is not surprising that after surveying our field and looking at what we did not have, we concluded that an educational program was going to be our major objective, certainly the first thing we would try to do and the thing on which we would spend a great deal of time and effort.

Three localities in the State were selected as offering potentialities for successful work, and to each one a representative of the program went, always conferring with county commissioners, judges, district attorneys, church and school officials, and various club and civic leaders. The purpose and possibilities of the program were explained and met with whole-hearted acceptance. The only question raised was by county commissioners, who asked what it would cost. In some cases they agreed to participate to a certain amount. The commissioners in one county said, for example, "Well, that sounds pretty good, and if you don't ask us for more than $25 a month it will be all right." Office space was arranged for in each of these three localities, either with the W. P. A. office if there was one, or in a county building. It depended a little upon what was available and what seemed in the county to be the place where we could cooperate best without having any "foreign entanglements."

A point was made of becoming acquainted with the members of our legislature and of showing them as early as we could some of the things that we did not have that could be remedied by legislation. We were promised by them everything that could be done. In fact, the slogan was "Anything for children."

We are singularly fortunate in that the plan drawn up by the State and approved by the Children's Bureau set the standards for workers high. That is, they were high in the sense that there was nothing in the State and no personnel standard that we had to shoot at, and certainly high in comparison with the equipment of some of the local workers and of work that was being done around us. It specified, for example, that each worker should have a minimum of 6 months' training in a recognized school of social work, plus some experience. Three workers were available in the State at the time that we began. These three were immediately absorbed into the program. They were young and enthusiastic about pioneering in social work and were thoroughly imbued with the principle that patience and understanding must prevail and that any seeming progress was not real progress unless the entire community understood and accepted what was being done.

We encouraged very active community participation in making plans and in carrying them out. Practically every service club in the various communities in the State has at some time in our history contributed financially toward carrying out plans for a child. Their natural interest in the welfare of children has been fostered by making them quite active participants in what was being done. We have, for example, service clubs contributing toward the care of tubercular children in a sanitarium outside the State; toward foster-home or convalescent care for children; toward supplying special medical needs and obtaining training in a school outside the State for two boys whose behavior was tending toward delinquency.

Within a few months after the child-welfare-services program began we secured a small State fund of $2,000 to be used for child-care purposes. This money seemed a lot to us, and we tried in every case to use it to match local funds or to care for a child temporarily when we hoped and thought that some person or service club in the community or county would later take over the care of the child. That is, we tried not to start financing out of $2,000 anything that might continue over a very long period. In the first year this fund paved the way for a total expenditure of $12,000. Practically all of it was collected from counties and service clubs and all of it was spent on types of cases that had previously received no care or attention whatever. The public interest gained through this little "bait fund" has been centered, I think, on getting money for us, and surely we will have more money after another session of the legislature.

The work that we did at the orphanage has been a great source of pride to us. The chairman of the board was an excellent person. He was the State superintendent of education and he had a fine philosophy of what children needed and what children should have. Working with him we made plans for removing unfit members of the staff, outlined changes in the institution itself, and arranged to place a social worker there. There was a legislative investigation of the institution at the time we were interested in making changes, and this helped in accomplishing some of our ends by arousing interest in providing a better staff, so that at the present time the social worker who is out there is working in a very different place. The rigidity of rules and discipline has been dispensed with. A much better superintendent is there. Some of the poorest staff members have been removed, and the children themselves are in a much happier frame of mind. Some of the children who were definitely feeble-minded have been removed from the orphanage. One girl who presented a very serious behavior problem has been removed, and the attitude of the children toward one another is being helped a great deal.

Similarly, we have introduced social-service work for the boys at the Nevada Industrial School. Plans for the release of the boys are made now in consultation with the local child-welfare worker and the workers in whose areas the boys will be placed.

It is hard for us, now that we have so much more at our command and are able to do so much more than in the beginning, to realize that it was only 2 years ago that we had so little. We feel that we have accomplished a great deal in that time. It seems, for example, longer than 2 years ago that we were in the dark basement room in the W. P. A. office, being constantly cautioned about what we should or should not do in the State.

We have now the beginning of a State welfare department that will provide quarters for the child-welfare-services workers. We have State participation in administrative costs. We have six child-welfare workers in the State, including the one at the orphanage. We provide social service for boys at the industrial school. We have an increased relief fund, and the prospect for future developments of our program are very bright indeed.

In March 1937, a constitutional amendment was adopted which made it possible for the State to participate in relief programs. It was possible then for the State to enact a welfare law providing for a welfare department and to provide an administrative appropriation. The law gives very general authority. It is very broad and it gives the child-welfare-services program legal status which it did not have before. A portion of the appropriation accompanying the welfare law has been set aside for our use and we are assured of State participation in administration.

In a State as small as Nevada, small from the point of view of population, the direction of the growth of our program will depend very largely, we believe, on the growth of the welfare department as a whole. Besides our division there is only one other operating in the State at the present time and that is the division of old-age assistance. We hope in the future to include aid to dependent children, aid to the blind, and supervision of general relief. The two existing divisions are very closely related. Some people are employed as half-time workers on each program, and at various times we have lent workers for 3 or 6 months on a part-time basis to the other division. Our aim is to consider our workers as employees of the department rather than of their particular division. The educational qualifications of our workers are higher than those set forth for workers in old-age assistance, and our emphasis on high training and qualifications has been felt very decidedly by the workers in old-age assistance. We have maintained throughout our existence a training program to enable one or two workers a year to have educational leave for 6 or 9 months.

Three of the workers in old-age assistance have asked for an opportunity to participate in our training program and to work part-time with us when they return. We have already given this opportunity to one of the workers. Another is going to have some training later in the year. Another encouraging sign that we think is going to build up a better personnel in the State is that three members of this year's graduating class in the university are going to enter schools of social work and finance their own training.

We are strongly inclined in Nevada to hold out for workers from our own State. As we did not have enough trained people when old-age assistance went into effect to provide qualified persons for all positions available, we took the best ones available in the State. One by one, through a process of infiltration and training under the programs that we are offering, these people are being added to the list of trained employees. It is a great source of pride to the State board that better personnel are being acquired. The wholeheartedness of the State board in doing the best possible work is evidenced in its recent request to the supervisor of the old-age-assistance and the child-welfare-services programs to make recommendations for a closer consolidation of the two existing divisions, looking forward eventually to a staff able to function in any division of the department.

We hope that it will not be very long before we are able to assign our workers on a county or a district basis and have each one capable of handling all the social work in that area. Child-welfare workers are now supervising, in almost every county, all the grants to mothers under the county law, and in many cases they are supervising general relief cases also. One county has already asked the State department to send a qualified person who can do all the work that needs to be done, because there is no one in the county really able to do it.

The place of the child-welfare-services program has been a very significant one in the development of the State welfare department and in making social work acceptable in the State to those who thought it was not needed. Individual cases have brought to the attention of the public the need for State provision for the care of the tubercular and feeble-minded children who are now charges on the county and who therefore are being given little care in most counties. Widespread interest has been aroused in remedying defects through legislation. Improved legislation relating to adoption, juvenile-court procedure, and general welfare work can be enacted probably at the next session of the legislature. Many groups in the State are coming into our office to say "Well, what can this organization do?", or "How can we help you accomplish the ends that you have in mind?" Thus, reviewing the developments, slight though they have been, and the anticipated developments, and remembering the former general apathy in the State toward social work or any kind of welfare work, we are sincere in saying that the State child-welfare-services program in Nevada really has meant everything.

The CHAIRMAN. You have heard the very interesting story of what has been happening in the State of Nevada and how they began from scratch, as it were, in the building up of welfare work. We are now going to hear from a State that had gone quite a long way along the road of public welfare when the Social Security Act came into being. I am glad to introduce Miss Winifred Lockard, one of the county children's workers in Wisconsin.

What Child-Welfare Services Have Meant From the Point of View of County Development

By Winifred Lockard, *County Children's Worker, Burnett County, Wis.*

Before I can begin to tell you exactly what child-welfare services have meant in Wisconsin, I should like to describe briefly what kind of county I am speaking of. Burnett County is one of the so-called rural counties of northern Wisconsin. It has a total area of about 566,000 acres. One-quarter of that area is zoned for recreational purposes, which in itself sounds rather ideal from the point of view of the child. Unfortunately, the area so zoned is not developed. In August 1936, 26.6 percent of all tax levies on real estate was delinquent. In December 1937, according to a survey made by the public-welfare department, 23.4 percent of our total county population was receiving some form of public assistance, through the Works Progress Administration, old-age assistance, aid to dependent children, or some other type of relief. Naturally all of this has had an effect on the child-welfare program and on the resources that we could expect to develop within the county.

At the inception of the program in June 1936, Burnett County was given a part-time worker who devoted 10 days a month to child-welfare work in the county. After approximately 1 year of this type of arrangement we were given a half-time worker, and since September 1937, we have had a worker who spends her entire time in the county. Fifty percent of her time is devoted to cases in the public-welfare department, cases in which there are children's problems. The other 50 percent of her time is devoted to cases assigned by the juvenile court, the county children's board, or interested persons in the county. This has had obvious advantages. It has shown the community that the family is the basis for treatment. These services were not so emphasized before and the community has not seen the tie-up and neither have the workers.

Another advantage of relating child-welfare work to family problems, which is probably the one which the community appreciates more than any other at this point in our program, is the financial advantage. There is less duplication of time and effort. The only disadvantage is that whereas the activities are integrated at the county level, the State still differentiates between the two fields. One State department deals with child welfare and another department deals with public welfare. There is also a State pension department, which is a misnomer since it handles old-age assistance and aid to dependent children. We do have many cases referred to us which we cannot handle, but we work with the area investigator and we confer with her on cases in which the children are in families receiving aid to dependent children.

Now I should like to discuss briefly the specific problems we have encountered in our work. Probably the first is that of selling ourselves to the community as individuals. A rural worker has to have more than the usual amount of imagination, I think, and a special ability to adapt herself to community standards. Those of you who come from a rural community will agree with me that standards of conduct are rigid. A rural worker has to learn the standards and abide by them, regardless of the different standards which may have prevailed in the community from which she has come. After you have sold yourself as an individual, you must sell yourself with relation to your program. I sometimes hesitate to use the term "personality" as a desirable attribute of any worker, but I think that if we consider it as William Allen White did when he said that "personality is the individual's social stimulus value" perhaps we may have the future of our child-welfare program depend upon the personality of the persons chosen to carry it out.

After we have sold ourselves, if we do succeed in that, we must go ahead and deal with the county in a practical way. First we have to decide what shall be our point of concentration. If we choose interpretation as a major part of our program, are we to go around talking to community groups, acting as gadflies, stimulating the community to approach the preventive aspect of the problem, and are we not also to act as integrators of the various resources which we find in the community? Although we do not have an advisory committee in our community, many of the counties of the State have chosen an advisory committee which meets with the children's board. Other counties which do not have a children's board have only an advisory committee made up largely of lay people, sometimes with some professional people, if they are available in the community, and these persons help in interpreting the programs to the groups which they represent.

Another problem which we have found to impede our progress is a lack of recreational facilities. We do have a State-wide recreational program which has a branch in our county. Unfortunately, however, there are such things as quota restrictions of the W. P. A. These quota restrictions do not permit the employment of noncertified persons on the program. Consequently the program must have as its leader someone from a certified group, which all too often, in our rural communities, does not include persons who have any special leadership ability or any special knowledge of recreational programs or the types of things that can be worked out. Incidentally, the areas of our county in which there are no villages, and we have only four, the largest of which has a population of less than 800, are not touched by the W. P. A. program at all, because, unfortunately, the leaders are not furnished mileage and cannot afford to go into other areas at their own expense. That throws us back upon the schools for our recreational facilities, but if you go into most of our rural schools you will be fortunate if you find a swing in the playground. I wonder why they call them "playgrounds" because they are not. Usually it is just a bare space adjoining the school, and the children, if they have anything to play with, have it because they brought it from home. This is due not only to the fact that funds are lacking but also to the fact that the school-board members never had those things when they went to school, so they do not understand why children need them now.

Another problem in connection with the schools is that of the superior and the retarded child. We have all talked a great deal in the past few years, nationally and in our States and local communities, about the conservation of natural resources. We have said much too little about the conservation of human resources, and I am thinking particularly of the superior child in the rural school. He is many paces ahead of most of his fellow classmates and has a teacher who perhaps is not quite in pace with him and who has no conception of how to guide him and no understanding of his interests. If the child has no one to guide him, his energies are going to be turned into destructive channels. Neither does the retarded child receive the treatment or a course of work adapted to his ability and needs, and it is hard to see what chance either of these groups of children has.

The housing problem is an acute one in the county. Many people live in poorly constructed tar-paper shacks. They do have the advantage of being well-ventilated, but in winter weather that is not an asset. Many of them have one or two rooms. Sometimes they have three rooms, but that is rare. Families of 8 and 10 and 12 live in those tar-paper shacks throughout the year. That situation has a tremendous effect on moral standards. How can we go in and say, "Well, look at the effect this will have on Johnny, all living here together like this. Why don't you move out?" Where would we move them to? There are no houses for them to move into. If there were, how could they pay the rent? We can't say, "You will get the rent paid by the relief office." Tied up with the housing situation is the inadequacy of relief. Relief is administered by the local units of government, which receive a small grant each month from the State. This takes care of about 50 percent of their needs, and their conception of their relief needs is just about 50 percent of that of the State relief office. As the situation exists now, the people are fortunate, indeed, if they get food, much less shelter. It is hard for us to try to raise standards of living. In fact, we question whether we should even suggest it. The standards of living are not satisfactory, but we know very well we cannot get an increase of relief funds by talking with the county chairman.

We have a small Indian population in the northernmost section of our county. There were, according to the last census, 224 of them, and they create their own special problem. Their cultural background is different from that of the white population. Their physical history is different. The greater percentage of our tubercular people is found amongst the Indians in this county. In a recent meeting which we held relative to Indian problems, I was interested to hear the educational field agent of our Great Lakes Indian agencies, who is himself an Indian, express the viewpoint that basically most of our Indians have a deep feeling of inferiority, which affects their reserve, their apparent inability to understand, and their lack of ability to adapt themselves to the standards of the communities in which they live.

We also have wondered about the younger generation of Indians who apparently have assimilated some of the standards of the community in which they live, yet are using the cultural patterns of their tribe as an excuse for their actions or deviation from the standards set up by white Americans.

I have cited a great many problems, and it sounds perhaps as if we are not getting anywhere except in contemplating the problems and that we are throwing up our hands, but I should like to tell you what our accomplishments are. Thus far in Burnett County we have done something in the way of publicity. We grant it is not nearly enough. We have had some newspaper articles; we have talked to various organizations and clubs; we have done a great deal of talking to our local officials. At the time of the last county board meeting in November the secretary of the children's board presented the report of the children's worker and the children's worker also cited illustrations of actual case work so that the board members might understand what our aims are and what type of work we are trying to do. Mimeographed copies of this report were given to all the board members so that they might peruse it at their leisure. Copies were furnished the rural-school teachers, the principals of the four high schools in the county, the presidents of the women's clubs, the American Legion auxiliary, the editors of the newspapers, and various other groups.

We had a mental and health clinic at which over 200 children were examined. They were given dental examinations, their eyes were examined, and about 30 of them were given mental tests by a psychologist from a State department. We were not able to do as much follow-up work as we should have liked to do, as far as the physical examinations were concerned. In the first place, we could not do so much with the children who were from families not on relief because the communities' attitude was that they were not going to pay for medical expenditures unless they were absolutely desperate cases, but the welfare departments did all the follow-up work recommended for the children from relief families. The mental tests were of great help to us because many of them were given to persons with whom we had been working for some time. Since then we have had brought to our attention other children who were tested, and on the basis of mental tests we do have a little better idea of the type of children we must cope with.

One of our little villages with a population of about 500 has in it a high school which draws its students from neighborhood towns. The young people come into town and board at the various private homes in this village, but they are without supervision except that provided by the families with whom they live. As a result, these children were walking the streets and spending their time in taverns, and some of them clubbed together and stayed in one house by themselves and did their own cooking. The situation became rather acute, and the social worker and the children's board met to discuss it and called in various persons from this village. The school board took the initiative and appointed teachers to make regular visits to these children in the homes in which they were living to discuss the problems of the pupils with the families and to see that they were not spending their time on the streets and becoming involved in difficulties. A curfew was also established. This method has really worked out very satisfactorily, and we have heard frequently from this community expressions of gratitude for the interest the children's board took at the time it was needed.

One project in which we are particularly interested is a council which we have organized in the northern section of the county, in the community adjoining the place where the Indians live. Practically every problem conceivable presented itself in that community. We decided that something should be done, so we called in the various people of the community who we knew were interested—the town treasurer, the county health officer, the county chairman, the county treasurer, a storekeeper, a scout master, a member of a scout committee, and other persons. We also called in the high-school principal and teachers and other persons from the county who did not live in the community but had connection with it. We called in the county judge, the county pension investigator, the county nurse, the nurse for the Indian agency, and the Indian educational field agent. We had quite a meeting. Each person presented the problems which he encountered in the community, his place in the community, what he had been doing and what he could do, and any suggestions he might have. We met from 8 until about 12:30 one evening and these members from the community seemed quite appreciative and took our suggestions to heart, not only listening but actually writing them down. As a consequence, a curfew was established in this village. They appointed a truant officer. It was decided that a library should be established and the next question was where to locate this library. It was suggested that the barber shop seemed to be the only place in town with sufficient extra space to house the books; the barber gave his consent and the library was established. All of that came out of one meeting. I have been in that community several times since then, and every time I set foot on the street these people crowd around and tell me what they are doing and ask what I think of it. I think that is just one example of the type of thing we can do if we want to. Too often we don't realize that we can do it.

We have established an unofficial advisory committee in our county. We don't call it that because the children's board was not enthusiastic about it, so we did not say anything about it. We just kept inviting other people to the meeting and the board accepts them and think it is a fine thing. These people consist principally of pension investigators, the county judge, the county supervisor, teachers, and county nurses. When we have a specific problem we invite other people who can throw light on the problem.

Another evidence of what we like to think is our progress is the fact that the problems presented to us mainly are problems in which preventive work is possible. I could tell you of a lot of little aims that we have worked out for various sections of the county, but I won't take your time to do that. I should like to mention that I think we are realizing more and more that our program depends upon our conceiving the ideal situation in our localities and then adapting it to the real situation. We must not forget that we must aid the individual to develop to the maximum of his ability so that he may be of most value to himself and to the community. But we must not forget that we tap the county's resources and develop them so that they may be of the greatest help to the individual.

The CHAIRMAN. A dozen years or so ago it was my pleasure to visit a State which was then outstanding for its development of a county welfare program. I am very glad to see selected as a speaker on the program this morning a representative from North Carolina, who will speak from the point of view of services for special groups. Mrs. Phyllis O'Kelly.

What Child-Welfare Services Have Meant From the Point of View of Services for Special Groups

By Mrs. Phyllis O'Kelly, *County Children's Worker, North Carolina*

I want to present to you some of the particular things that the Negro social worker, under the child-welfare-services program, has been doing for the Negro child. Child-welfare services have meant for the Negro child in North Carolina extending the present program and placing special emphasis on case work, and I think that this has meant a great deal to the Negro child.

When we think of child welfare there immediately comes to our minds that phase of activity that has to do with the well-being of the child. Specifically, it may mean recreational or group work with children and care for the physically handicapped, the mentally deficient, the delinquent or predelinquent, and the neglected and dependent. Child-welfare services under the Social Security Act have permeated to some extent all of these areas of child welfare and have made such services available to children in need of specialized care. The worker under this program has been expected by the local community to fill adequately the role of one equipped to deal with all of the above-mentioned aspects of child welfare. More than that she has had the job of interpreting her role to the community. Gradually there has been aroused in the communities where the workers have been placed a consciousness of that community's problem in meeting the need of the child. The child-welfare-services worker has demonstrated the existence of such a need by her handling of the problems with the limited facilities available for carrying out a plan of treatment in a particular situation. If facilities have been limited in general for meeting the child's needs in the community, this limitation has been felt to greater extent in child-welfare services to special groups. Here we have in mind particularly the Negro child, who has had very few resources, local, State, or national, that could be used to serve his need efficiently. Child-welfare services have entered into the field of Negro child welfare, and since their recent beginning they have made an inestimable contribution to whatever programs were in existence for understanding and meeting the needs of the Negro dependent, delinquent, or neglected child.

Reviewing briefly the situation of child welfare in North Carolina before the time of child-welfare services, we find that there were eight institutions caring for Negro children: One for delinquent Negro boys, public; one for delinquent Negro girls, privately operated and subsidized by public funds; two Negro orphanages; a ward of the State Orthopedic Hospital for the care of crippled children; a ward for the treatment of the feeble-minded and epileptic Negro child at the State Hospital for the Negro Insane; and an institution for the blind and the deaf. The institution for delinquent boys had few facilities for adequate case-work treatment; that is, there was no social worker at the institution to study the needs of the child and to bring together the interest of the community from which he came and the interest of the institution to which he was sent. Nor did the institution have available the services of a psychologist who might help in determining the needs of the child. The institution for delinquent girls represents a noble effort, inadequate though it may be, on the part of the Federation of Negro Women's Clubs of North Carolina to meet the needs of the maladjusted girl. The provision made for the feeble-minded Negro child by no means met the problem. Nevertheless, we can say that in spite of these inadequacies there was, to some extent, a program for Negro child welfare well on the way in North Carolina when the present specialized services became available. From such a beginning let us review for a few minutes some of the outstanding contributions of this program to the Negro child.

Child-welfare services have meant, first, an opportunity for the understanding of the child in his local community. Negro child-welfare-services workers were placed in sections of North Carolina thickly populated by Negroes, one county worker in the northeastern section, another in the southwestern section, and a third in the central area serving the children in a three-county unit. These workers are not only giving individualized treatment to the maladjusted Negro child and arranging care for the dependent or neglected child, but are also making the community itself more aware of the need for such service. The following summary of a case was received from one of the Negro child-welfare assistants.

Mr. J., serving a 20-year sentence, requested assistance for his family and the opportunity for his children to attend school. His wife and five children were living with Mr. J.'s father, who was unable to support them. The child-welfare-services worker gave Mrs. J. the opportunity of expressing her ideas about her financial, physical, and social needs, and her feeling toward the persons and officials who, she felt, might have defended her husband when he got into trouble 8 months before. The next step was to learn the attitudes of the community toward the J. family and to interpret the family's needs and attitudes to the community. Twice the family had been denied public and local assistance by board authorities because influential citizens felt the family's deprivation was a part of Mr. J.'s punishment. To them the family were carriers of venereal disease and "no good." Through the efforts of the child-welfare worker a grant was made available and medical service was given. The children are now attending school.

Secondly, child-welfare services have meant increasing the facilities already available for the study and treatment of the delinquent Negro child in the institution and in the community. There is now a case worker on the staff of the State institution for delinquent Negro boys, and a psychologist visits the institution and the local county unit to aid in the better understanding of the cause of behavior difficulty. The social worker at the institution began immediately to make the local community from which the committed child came plan in his behalf. If the child was found to be unsuited for the type of care that such an institution could give, plans were immediately made for his return to that community or to an environment more suited to fill his need. There is now more careful study of the children and the communities' facilities before commitment, so that mentally deficient, dependent, or neglected children are not so frequently sent to the institution because the communities have no other place for them. The county children's worker has found the cooperation of the case worker at the institution an inestimable asset to her in making plans for the child who is being dismissed or paroled from the institution.

Thirdly, child-welfare services have meant the bringing together of all available resources to provide adequate care for the family as a whole and intensive case-work service for the individual problem child.

Finally, child-welfare services have placed a new emphasis upon the need of the child to grow up in a normal home environment, his own home if possible. The following case illustrates what has been done through the children's worker in returning a child to her home after 3 years in foster care.

A girl of 5, reported neglected, was taken into the custody of the welfare department in 1933 and was sent to the Orthopedic Hospital for treatment of a crippled foot. When released she was placed in one free home and then another. Nothing was done in the meantime to relieve the poverty-stricken condition of the family of six, who were sleeping in two beds, the remaining furniture consisting of a cook stove, a table, a bench, and a kitchen cabinet. The services of the child-welfare worker were requested when it was reported that the foster parents were abusing the child. The parents, who had heard nothing of the child in some months, were eager to participate in any way they could to improve their home condition so that their daughter might return to them. In a few months' time the family was given additional furniture. In exchange for labor the landlord repaired the home and gave them the use of the entire house. The child herself was eager to return to her family. Although her own home is not so well equipped physically as the foster home, the child has made an adequate readjustment to her family.

Even if child-welfare services meant no more than making available the above-mentioned services for Negro children, their contribution could not be overestimated. But together with meeting some of the problems facing special groups of children, these services have deepened the realization of our inadequate facilities for a well-rounded development of the Negro child. We need boarding homes to give either permanent or temporary care to the Negro child, homes which can meet the State's requirement. We feel the need for those facilities that can help us in our treatment of the maladjusted Negro girl and the mentally deficient child. We are more conscious than ever of the need for a school curriculum that is made to meet the needs of the child and not to make the child fill the need of the curriculum. In short, child-welfare services have given us a perspective of the needs of Negro child welfare, have increased our resources for specialized treatment, have developed an awareness of the need for a better understanding of the Negro child, and finally have brought us face to face with the limitations of our present facilities for a well-rounded program of child welfare.

The CHAIRMAN. Well, we have dipped into three States just as samples. I am sure this gives us a background for the further discussion which is to take place this afternoon.

Monday, April 4—Afternoon Session

RELATION OF CHILD-WELFARE SERVICES TO AID TO DEPENDENT CHILDREN

Miss Anita J. Faatz, Director, Social-Work Department, Maryland Board of State Aid and Charities, Presiding

Miss Atkinson. We are very glad this afternoon that we can have Miss Hoey with us, because we want to spend a little time considering the program of aid to dependent children in its relation to child-welfare services.

The fact that the people who are doing child-welfare services are not always the workers having responsibility for administering aid to dependent children does not mean that there is not an interest in that program. We have been saying in this country, since the first White House Conference, that children should not be removed from their own homes for poverty alone. The passage of the Social Security Act, which broadened the old mothers' aid laws so that they include a much more flexible program of aid to dependent children, is regarded as a great step forward in this thing which we call child welfare in its broadest sense. There has been a tendency in some parts of the country to think that with enactment of legislation the job was ended and we would have adequate protection for children in their own homes.

We know that there are still many hurdles to be taken. We know, for example, that there has been a much more vocal constituency for the old-age group than has been true for the children's group. We believe that the purposes of the act which created the Children's Bureau, namely, that the Bureau should be concerned with conditions affecting children, make it a fit and proper procedure for us to give this afternoon to a consideration of the relationship between these two programs. I am very glad that Miss Hoey, who has as great concern about services to children as any of the children's workers in the States or in the Children's Bureau, is here to express to you the point of view of the Social Security Board and the objectives and the possibilities that the Board sees in the administration of aid to dependent children.

Miss Faatz, who is director of the social-work department of the Maryland Board of State Aid and Charities, will be the chairman this afternoon.

I shall now turn the meeting over to Miss Faatz.

The Chairman. I listened to Miss Curry open the meeting this morning and felt deeply grateful to her for reminding us that things are really happening, because, as a matter of fact, the old phrase of not being able to see the woods for the trees is all too true of those who are in State and local jobs. It is also a bit like looking at the hour hand on the clock, which you cannot see move but which is in a different place at a different time if you have the opportunity to stop long enough to look at it. I was interested to hear Miss Atkinson say, for purposes of the record, that all parts of the program are one. While I don't have the historical perspective of the public-welfare program that Miss Curry has, I do feel, as I am sure a good many of you here do, a little battle-scarred by the emergency-relief program, as though if we have not been at it quite so long we nevertheless have lived very fast in the last few years, in a much too quick and too hectic existence at particular times.

As I sat in the audience this morning listening to the comment that the juvenile court had made the child visible, I could not help thinking of the pounds and pounds of surplus commodities, C. C. C. enrollments, W. P. A. certifications, and so on, under the weight of which we sometimes lose sight of the individual. We do lose sight of the child all too often in our general work with families.

I am particularly interested, and also particularly grateful, that the purpose of the meeting is to discuss content rather than administration, and I also am gratified to be part of the program to discuss the family program from the standpoint of aid to dependent children and the child-welfare programs. With these comments, I will introduce Miss Hoey, who is well known to all of you.

Objectives in Aid to Dependent Children

By Jane M. Hoey, *Director, Bureau of Public Assistance, Social Security Board*

To those who do not look beneath the surface, my topic may seem like one of those unnecessary questions that answer themselves. It is easy to say that the objectives of aid to dependent children are self-explanatory. And it is easy to give legal definitions as set forth in the Social Security Act and in the laws of the several States. That is all right as far as it goes; but it is only a very small part of the answer. Beyond this, what does this Nation-wide program imply? Have we thought through, step by step, what our immediate objectives and our long-term objectives should be—on the Federal level, in the States, and in local communities?

In analyzing objectives, we must begin by restating the basic relationship, as conceived in the Social Security Act, among these three units of our American Government. The relationship of the Federal Government is with the States, and the purpose of the Federal program is to strengthen the State programs. To this end the act promulgates certain Nation-wide standards designed to assure minimum essentials, provides for Federal grants to States with plans approved as meeting these standards, and authorizes the Social Security Board to cooperate with the States in developing their programs. The State has a two-fold relationship—with the Federal Government on the one hand and with its own local communities on the other. It is responsible to the Federal Government for the administration of its program in accordance with basic national requirements in all parts of the State. But this is only the beginning. The Social Security Act reserves to the States a large measure of discretion in setting up and administering their own programs. Building on the foundation afforded by the Social Security Act, the State therefore has a major obligation to help all its local communities in continuously improving their services to dependent children. These local agencies are the most important link in the chain; and this is equally true whether the program is directly administered by the State agency through its own district offices or whether it is locally administered by county agencies under State supervision. For the local community is the only point at which the "plan" and the people meet. In the last analysis, everything we do at the Federal level and at the State level has this one purpose—to promote effective and constructive local services to individual children and families in each community. In all that we do we must keep this fact clearly in mind. But at the same time we must be equally clear as to the area of responsibility within which each level of government must operate if it is to make its proper contribution to this program.

The Social Security Board has interpreted its relationship with the States as one of genuine cooperation. It has not been content merely to see that States receiving public-assistance grants conform to the letter of the law. This is, indeed, an essential part of its obligation to the country as a whole. Beyond this, however, the Board believes that it also has an obligation to give the States all possible help in developing their own programs. But true cooperation is a two-way process, and the Board realizes that the experience gained by the States in administering aid to dependent children is the major source of increasing knowledge and understanding in the field.

In line with this liberal conception of Federal-State cooperation, the Board considers service to State agencies to be one of its most important immediate objectives. Through its Bureau of Public Assistance it acts as a clearing house for State experience and is endeavoring to make more services, based on this experience, available as rapidly as possible. These services are carried on in part in the field through the Board's 12 regional offices, and in part through its staff in Washington.

The Board, as you know, reviews all State plans as they are submitted. These plans are developed by State officials. But members of the Board's field staff are available for consultation, if the State wishes, even in these preliminary steps; and most of the States have called upon them for extended consultation during the development of their plans. After evaluating the plan and studying the field reports of regional representatives, the Board may suggest to the State changes that seem advisable either in its legislation or in its proposed organization. After the plan is approved, regular contacts between the field staff and the State agency are continuously maintained, and reports are made both to the State and to the Board. To supplement this regular service, and for the use of both the State agencies and its own representatives, the Board's Bureau of Public Assistance has been developing a body of written materials, based on the past 2 years' experience in the States. These suggestions are being sent to the State agencies for adaptation in line with their own procedures and policies.

In addition to this regular service in the field and from Washington, the Board makes a variety of special services available. Consultants on the staff of its Bureau of Public Assistance offer the States advisory services on matters of personnel, family budgeting, technical training, and other special fields. Such services are of value not only in dealing with particular problems but also in promoting a well-balanced development throughout the State program.

This is true also of the administrative studies made by a division set up for this purpose in the Bureau of Public Assistance. It often happens that a State agency is interested in surveying the actual operation of its public-assistance plans but lacks facilities for this kind of detailed study. If so, the Division of Administrative Studies will cooperate with it in making a survey. This is simply an extension of the Board's regular field service. Sending in this specially equipped staff helps the State to see what is happening within its own boundaries.

In accordance with the Social Security Act, the Board, as you probably know, has held two hearings with regard to improper administration of State public-assistance plans. Though administrative studies preceded both these hearings, this does not mean in the least that every study leads to a hearing. Most of the studies made have had no such outcome. Their major purpose is simply to furnish an objective, impartial view of how a particular program is working out.

The Social Security Board offers the State agencies other special services in addition to those of its public-assistance staff. For example, in cooperation with the Bureau of Public Assistance, the Board's Bureau of Research and Statistics and its Informational Service assist the States whenever they want advice in their respective fields. In the same way the Board's legal staff has given consultative services to some States. When public-assistance cases have been taken to court, regional attorneys have, upon request, occasionally advised with the State's attorneys in the preparation of their briefs.

The General Counsel's office and the Bureau of Public Assistance have also been working with the States in clarifying the relationship between the State attorney general's office and the State public-welfare department. The suggestions, which have grown out of the experience of various States, seem to offer a satisfactory working basis, and should be of interest to all those concerned with this aspect of public welfare.

Questions have also been raised with regard to fiscal procedures and relationships—between the State and its local communities and between the State department of public welfare and State fiscal agencies, such as the offices of the State auditor and the State treasurer. Here again the Social Security Board, through its Bureau of Accounts and Audits and other consultants on its staff, is prepared to assist the States in developing sound and effective practices.

These services have been of material help in clarifying some of the States' financial problems. But a still more important financial problem has to do with the basis on which Federal grants for aid to dependent children are made. Under the present terms of the Social Security Act the Federal Government matches State expenditures for aid to the aged and the blind on a dollar-for-dollar basis, while for aid to dependent children it gives $1 of Federal money for every $2 of State and local money. It seems probable that this differential is at least one of the reasons why old-age assistance with 50 participating States and territories, has progressed more rapidly than aid to dependent children, in which only 40 States are taking part. For the past 2 years the Social Security Board has therefore been recommending that the grants for all three programs should be put upon a uniform equal-matching basis.

It would seem desirable also to make a change with regard to Federal grants for public-assistance administration. The Federal Government now pays one-third of the total cost, including administration as well as assistance, for aid to dependent children; but for the other two programs it adds to its assistance grant a supplementary 5 percent which the State may use for assistance, administration, or both. It would be logical to expect that it would be to the best interests of effective administration if this 5-percent provision were eliminated and the act amended so that the Federal Government could pay half the total cost for both administration and assistance under all three programs.

Bills are now pending in Congress for another important amendment to the act to liberalize Federal financial participation in aid to dependent children. Under the existing provisions of the act, Federal grants are determined on the basis of a maximum of $18 for the first child and $12 for each additional child in the same home. This, of course, does not limit the State, which may pay more or less than this amount; but if it pays more it must make up the additional amount from State and local funds. The present limitation on Federal grants might well be removed so that the Federal Government could contribute its proportionate share of whatever allowance was called for on the basis of individual needs. If this is not feasible, the upper limit might at least be raised to $18 for all children aided.

So far these changes are no more than hopes, but many people, both in the Federal Government and in the States, are aware of the need for some such modification. It is not unreasonable to hope that these long-term Federal objectives will be realized in the not too distant future.

It seems clear that one of the immediate objectives of the States should be complete coverage of all children who are "dependent" within the definition of the Social Security Act and for whose care Federal grants are available. Approximately 554,000 dependent children in over 222,000 families are now receiving allowances from Federal, State, and local funds under this program. Compared with the 122,000 families who received mothers' aid in 39 States in January 1936, the last month before Federal funds became available, the present coverage represents an increase of about 82 percent. But 10 States are still taking no part in this program, though they may, of course, still be operating under State mothers' aid provisions. Even in States that are participating, the extent of coverage varies greatly. The number of children receiving assistance, as compared with the total population under 16, ranges from 41 per 1,000 in some States to less than 10 per 1,000 in others. Taking all the participating States together, the average stands at about 19 out of 1,000, though the best estimates available indicate that this is lower than the number who might conceivably be eligible for aid if all the States adopted the definition of dependency in the Federal act.

One immediate objective is, then, to extend State participation until this Federal-State program is Nation-wide. Another is to extend aid to dependent children within each State until it reaches all children who are in need of and should be eligible for this kind of assistance and service. In a number of States this second objective has obviously not been reached. In some the definition of a dependent child in the State law is less liberal than that in the Federal act. In others the legal definition is sufficiently liberal, but its application is hampered by opinion and attitude. Children may, for example, be excluded from this program because their parents' behavior does not conform to a certain pattern. The transfer from general relief to aid to dependent children in some States thus seems to be made on a basis of "promoting the nice families." This is hardly a sound method of selection, and it is certainly not in accordance with the intent of the Federal law. Moreover, since most of the families so excluded are in need and require some kind of public care in any case, denying them aid to dependent children is particularly short-sighted. It simply means that they are thrown back on general relief or some other program. This not only increases the local financial burden but also prevents the Federal Government from helping the State and community take more adequate care of children who need the best help available. Families with dependent children should at the very least have the opportunity to receive assistance according to the objective standards established by Federal and State law. This is a basic essential if the interests of the children for whom this program was set up are to be safeguarded.

Another point at which the States need to safeguard the children's interest, is in the matter of family budgeting. This problem is particularly urgent in the many States where general relief is either very inadequate or nonexistent. Under such circumstances the Federal-State allowance for dependent children is sometimes expected to carry the budget for the whole family. This may mean that even though the maximum allowance is being granted the child himself gets very little. The family's total budget deficiency must, of course, be given consideration in determining the needs of any of its members. Though the Federal provisions for aid to dependent children do not include an allowance for the mother, general overhead expenses—rent, light, heat, and so on—may thus properly be charged to the aid given the children, as far as the State's available funds will permit. This is warranted by the fact that otherwise no home could be maintained for the children. But where such emergency expedients are necessary, great care must be exercised to protect the welfare of the children for whom the law is intended to provide.

Differences in budgeting practices, whether based on family needs or individual needs, undoubtedly account in some measure for the wide variation in the State averages of payments made to families with dependent children. For February 1938 the range was from $10.41 to $60.39 per family, with the average for all participating States $32.02. For old-age assistance and aid to the blind, which presumably are on an individual rather than a family basis, February payments averaged, respectively, $19.34 and $25.49. As has already been pointed out, the existing Federal provisions for financing aid to dependent children present serious problems, but there can be no question that one of the major goals of both the Federal Government and the States should be to make the aid offered to dependent children at least as adequate as that available for the aged and the blind.

Increasing coverage and increasing adequacy of assistance are, then, two of our most important objectives; but there is a third which is of at least equal importance—effective administrative organization. Everyone experienced in the public-welfare field would, I believe, agree that the most effective system of State organization is that in which a public-welfare department administers not only the Federal-State public-assistance and child-welfare programs but also general relief and possibly other State services. The establishment of a single State agency does not mean that all these activities are, as it were, to be dumped indiscriminately into a single hopper. Functions and areas of responsibility must be clearly defined, if confusion is not to result—as some States have learned from experience.

Sound organization recognizes both "horizontal" and "vertical" lines of relationship and facilitates coordination in both directions.

The horizontal lines are those that relate the various programs and services administered by the department. For example, from the point of view of administration the child-welfare service and the public-assistance division are separate and correlative units, though both may operate within the same agency. But the director and staff of the child-welfare program should act as consultants and advisers to the public-assistance division, in relation to aid to dependent children. Division of responsibility, plus cooperation in related fields, is a measure of really effective organization.

These horizontal lines are, on the whole, less likely to get tangled than the vertical lines which serve to integrate "overhead" administrative functions. Definition within this area should, if the agency is headed by a board, begin with the board-staff relationship. Otherwise the board may become involved in administrative details, even though its duties are clearly described in the State law as advisory. The board and the staff each has important responsibilities, but neither can fulfill them effectively unless it knows what they are. Within the administrative staff, three major functions must also be clearly distinguished and provided for—business management, including fiscal control; research and statistics; and social service.

State public-welfare programs involve large sums of public money and demand as much business efficiency as private enterprises of like financial proportions. It should be clear to everyone that this money is intended for the single purpose of providing necessary assistance and services for which government has made itself responsible. The social-service function of the public-welfare department is therefore the core and center of the entire organization, and it should be clearly understood that the social-service staff is responsible for all parts of the program that actually touch people's lives.

Special consultants also form a functional part of an adequate social-service staff. A home economist, for example, serves in an essential advisory capacity; and there are a number of other special aspects of the program for which the State agency will bring in consultants to work with its field staff, and, through it, with the local agencies. In addition, as in the relationship between child welfare and aid to dependent children mentioned above, the staff of one division may frequently be called into consultation by another division.

One of the major responsibilities of the State social-service staff is the supervision of local agencies. Failure to distinguish between these State supervisory and consultative functions on the one hand and local administrative functions on the other has caused much needless confusion in some States. Sometimes, for instance, a State staff undertakes to duplicate the investigations made by local workers or to check on the eligibility requirements as set forth in each individual case record. Neither of these practices seems satisfactory in terms of real supervision. The job of the State supervisory staff is, rather, to strengthen the local agencies, to supplement their efforts, and to help train their workers for their own everyday duties. The State agency must know what is happening in the communities, and it will make detailed spot checks upon occasion. But it should not attempt to do the job for the local agency, just as a Federal agency does not attempt to do the job for the State.

Another source of State and local confusion in some States is the lack of clear definition and information in matters of policy and procedure. In some cases State policies have not been put in written form and distributed to local agencies. In others, they have been sent out in occasional bulletins, which are too easily lost or misplaced. Or again, the content of bulletins may be superseded, without making certain that the local agencies are informed of the change. The State agency should maintain a comprehensive, up-to-date manual of which all local agencies have copies. These manuals, which might well be bound in loose-leaf form to facilitate changes and additions, should include all statements of policy, instructions, working plans and procedures, and suggestions for local agencies.

These are, of course, only a few of the problems of administration which the States are encountering, but they serve to suggest needs and trends in development. Increasingly efficient organization is important not only in the internal operation of the State welfare department but also in its external relationships—its contacts with the public. In view of current criticisms, it is worth while to make it abundantly clear that the department fully recognizes and is fully equipped to meet all its responsibilities, in business management, social service, and all along the line. Before this can be made clear it must be true. Sound organization speaks for itself. If the public sees that the business end of public welfare is well managed it will be better prepared to accept the need for social service administered by a staff specially trained in this field.

We hear a great deal of talk about the need for businessmen in public-welfare administration. But what are the particular functions they are equipped by training and experience to fill? If people can be persuaded to ask that, to inquire into the actual nature of the work to be performed, there will be less misunderstanding of personnel problems than there is at present.

As one businessman is quoted as saying, after he had his first view of public welfare from the inside: "I'm going to make a speech to my chamber of commerce. Those fellows think a department like this just spends money. I'll tell them this is important. It takes skilled people."

When people reach that point they will be ready to accept the idea that appointments should be made in accordance with the requirements of a particular job and that the social-service aspects of public welfare require trained social workers, as competent in their own field as an efficient businessman is in his. But in matters of personnel some of our objectives are not yet fully understood, much less attained, in many States.

This issue has been most discussed in relation to the social-service aspects of the program, no doubt because the need for adequate standards in this field has been most urgent and least recognized. We hope, however, that the selection of all State and local personnel—including clerical and administrative staffs and even "businessmen"—will be placed on a merit basis. I use the term "merit" advisedly, because it seems to me that civil service may or may not be on a merit basis. Regardless of terminology, we believe that the State agency should set up minimum objective standards of education, training, and experience, not only for the State staff but also for the local staffs. Standards for local positions should, of course, be worked out with the cooperation of the local agencies.

But simply setting up standards is not enough. Some States have tried to put through merit procedures with very good standards only to see the entire system overturned and devastated. The people of the State have not understood the issues involved, and without their support the agency has been unable to withstand the pressures placed upon it. A great deal of public education is still necessary before the public will be willing to accept and to stand solidly behind really adequate personnel standards.

Though we have a long way to go to reach this objective, we shall be deceiving ourselves if we assume that public acceptance is the only hurdle we still have to cross. We believe in adequate personnel standards and selection on the basis of merit; we are advocating them and working for them. But what beyond that? By what process of judging—by examinations or otherwise—are we most likely to discover what skills people really have and whether they are fitted for particular positions? We all know it is the "plus" that counts. But by what yardstick can we measure it? On what basis, too, can we best judge the quality of performance? Now that this program has been in operation for 2 years, is it not time that Federal and State authorities began to work out methods for evaluating performance on the job, both of individuals and of the staff as a whole—clerical, statistical, and administrative, as well as social service?

We have made a beginning at solving these problems, but only a beginning. A special unit of the Social Security Board's staff is cooperating with its Bureau of Public Assistance in helping the States to develop personnel standards on an objective merit basis. But in this area there is still too little detailed knowledge. The issues we are facing are analogous to those that already exist in other professions like engineering, medicine, and law. Surely we can learn something from their experience. In addition to exploring the questions as fully as we can ourselves, we must also stimulate research agencies, universities, schools of social work, and other groups to help us work them out.

This discussion of organization and of personnel has naturally carried over from the State to the local field; for all our objectives, not only at the State level but also at the Federal level, are directed toward the service given locally to those who are in need of help. Without the support and guidance provided by the State and Federal organizations, local agencies would, presumably, be less prepared to give dependent children and their families constructive care. But unless directed toward the development of effective local service, all the efforts of the State and Federal governments would be futile.

What we are all working for is adequate and appropriate assistance and service for each individual in accordance with his particular needs. During the period of expansion through which we have so far been going this objective has not always been realized. Too often the help offered has stopped short with meeting—more or less adequately—the money needs of families with dependent children. This limitation, this failure to consider the equally important service needs of such families, has not by any means always been due to deliberate intention. Often the pressure of work and the heavy case loads carried by local workers have made it impossible for them to do more. We all hope that in the next few years these handicaps will be overcome. When local agencies are more adequately staffed—both as to the number of workers appointed and as to the standards by which they are selected—they will be better prepared to give assistance *plus* service and not merely cash assistance, necessary as it is, without its equally necessary complement.

Another thing that seems perhaps even more important on the local level than elsewhere is the question of attitude—of the point of view of the worker. On all levels we must, of course, be objective. We cannot base decisions on emotion or prejudice, or anything but facts—and facts about a particular situation that have been carefully weighed with all of the knowledge and experience at our command. This may seem too obvious for further emphasis until we look at what is happening in some places. Allowances are sometimes, as it were, conditional. Parents whose behavior is not considered acceptable may be told, in effect, that unless they mend their ways their children will not get an allowance next month. Failure to fit a particular mold is assumed to be their own fault and to relieve the public agency of responsibility. That is most certainly not the intent of the Social Security Act nor of any well-trained social worker. But without facilities for good case work and with many workers who have had little or no social-service experience all sorts of short cuts are set up, and these inevitably preclude the possibility of giving families any real service in meeting their problems. We must help all the workers in this program to develop an attitude of respect for the individual and for his right to his own point of view. And along with this we must help the local agencies to develop both the concept of genuine service and the capacity to give it in the light of particular needs.

Wherever possible we must set up yardsticks by which we can measure the effectiveness of service. This is another important area in which little guidance is available. There is little in writing; and though a good many people have been thinking along these lines, we still have almost nothing to put into the hands of local workers—or of State and Federal workers, for that matter—to help them judge the effectiveness of a service program. We can do certain things. We can see that payments are sent out regularly and we can check on other routine procedures. But if anybody has found a yardstick for measuring how effective a service program is or should be, I, for one, should like to hear about it. Here again we need to do a great deal of exploration. I hope that in the next few years we can all work together to find constructive answers to our own questions.

But when all is said and done, the basic issue is aiding dependent children—and by this we understand not only cash assistance but also such services as will enable the family to maintain a relatively normal home and bring up its own children. In accepting this we accept also the premise that it is a good thing, wherever possible, to keep the child in his own home or with his relatives; or, if neither of these is possible, in some other family group. All our past experience and such insight as we have into children's emotional and social needs point in this direction. To the best of our knowledge this is the best we can do for the child. But it is best only if we recognize—and if we help the family to recognize—that the family and society together have a responsibility not only for the child's present but also for his future. He has a right to all the care we can give him, but that care should be directed toward helping him when he grows up to help himself. The final goal in aid to dependent children is the prevention of future dependency. And the final test of the care we give children today comes years hence when they go out to find jobs and make a place for themselves in the world.

There is no question that the public is behind the beginning and the end of this program. They believe in taking care of dependent children now, and they realize the importance of taking care of them in such a way that they will grow toward normal adult independence. It is the steps between that require interpretation. Such a program demands the highest type of service and this kind of service is expensive. We need to make it clear to the public that the money expended in such service is a sound investment. We need to explain our reasons for believing that "a good heart" is not enough and that experience and skill are essential. We need to make it self-evident that the program is organized and administered in the interests of maximum efficiency and effectiveness. We need to convince people that the public interest and the child's interest are identical and that we are working to safeguard both.

In some parts of the country these things are beginning to be understood, but in many places they have not yet been accepted. No doubt we, ourselves, are at least partly responsible for this lack of public understanding in that we have not interpreted our job so that the man in the street can see what we are driving at and why. Perhaps we have failed to understand the need for interpretation. Perhaps we have been so harassed and weighed down with the size of the job that we have forgotten it can go on only if it has community support. Whatever the reason for our past neglect, we must from now on devote time and effort to seeing that the community does understand and stand back of our methods as well as our objectives. Public-welfare agencies must themselves take the initiative in this broad program of public education. State and local boards that are really representative of all groups in the community—and we should all help to make them so—will be their most helpful supporters and interpreters in such a program.

This process of interpretation and education must extend not only to the community as a whole, but also to the children and the families who are receiving help. But before we can do either of these things we must undertake the still more important job of educating ourselves continuously and progressively. "Know thyself"—understand your own program, your own objectives, your own attitudes, and be sure that they are as sound as intelligence and experience can make them—that is the fundamental challenge to every one of us who has a part in this Nation-wide program of aid to dependent children.

The CHAIRMAN. Thank you, Miss Hoey. I should like to start right in discussing methods of evaluating what we are doing and problems of deciding what we do that is of value, and so on. However, we are going on for the rest of the program now. If this were a local meeting and if we stopped for just a minute here, a hundred to one somebody in some corner of the room would rise to his feet and say, "Miss Hoey, what is a suitable home?" That may still come out.

The next part of the program is a discussion of factors in the content of the program of aid to dependent children, and this time we go to Tennessee, with Mrs. Elizabeth Thompson, supervisor of aid to dependent children in Tennessee.

Factors in the Content of the Program of Aid to Dependent Children

By Mrs. Elizabeth Thompson, *Supervisor, Aid to Dependent Children, Tennessee*

There is in the Bank of England a delicate machine, a monument to the ingenuity of its inventor. The purpose of the instrument is to measure, within the smallest fraction, the weight and size of the coins of the Empire as they come from the mint and go into the economic blood stream of the nation. The coins are placed on a long slide and as each token reaches the top it pauses for a moment and is then cast either to the right, a perfect specimen committed to the service of mankind, or to the left, an imperfect and valueless object which must be remolded and reworked before it can possess any usefulness. Nor is it a far cry from a machine for measuring coins in the Bank of England to the program of aid to dependent children in the United States. There are those who see in the various State statutes setting forth the conditions of eligibility for this form of assistance, just such an automatic measure for determining who shall and who shall not be so benefited. It is peculiarly fitting, therefore, that we, as a professional group first, and then as citizens interested in the common weal, give thoughtful consideration not only to the administration of the public-assistance program for children but to what is included in that program, the content of the legislative enactments and their interpretation, the plans that we are putting into effect for the conservation of child life in the Nation.

Much has been said—Miss Hoey has gone into some detail—on the subject of the philosophy of the program of aid to dependent children as it has been set up, first by the Federal Government and then more recently by the several States. As in any good edifice the foundation was laid first, in this case many years before the structure was completed; and while the span of time between the White House Conference of 1909 and the Social Security Act of 1935 is a long one, it is solidly constructed. It is, of course, impossible to be aware of the fundamentals of social organization and doubt that "home life is the highest and finest product of civilization," that "it is the great molding force of mind and of character," and that "children should not be deprived of it except for urgent and compelling reasons." The 1909 conference report, so rich in historical significance, then goes on to lay down the primary principle that "except in unusual circumstances, the home should not be broken up for reasons of poverty, but only for the considerations of inefficiency and immorality" and, continuing, "such aid should be given as may be necessary to maintain suitable homes for the rearing of children."

The impetus thus given to the principle of aid for children in their own homes soon set in motion the establishment of public as well as private provision for such care. The mothers' aid laws of Missouri and Illinois, passed in 1911, were the beginning of a movement so popular that by 1934, 46 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico had enacted such legislation in one form or another. But as is so often true of purely statistical pictures, the fatherless children and their mothers in this country did not benefit so much as might be expected. What was the actual situation? Many of the mothers' aid laws were permissive in character. Many more depended for their financial provision on tax units that were too small, too unsound economically, or too limited by statutory provisions to carry the burden. The result? Many laws were not fully operative.

In one State, for example, only about 5 out of the 95 counties ever put the permissive State-wide mothers' aid law into effect, and in 3 of these counties the assistance was in reality poor relief to widows, the quarterly grant of $10 to $15 merely being glorified by the name mothers' aid. Thus in many localities the assistance, while being given to parents of "worthy character" as usually required by law, was totally inadequate "to maintain suitable homes for the rearing of children," as outlined in the White House Conference report.

The relationship between insufficient income and inefficient living, and, indeed, even immoral conduct, has long been known by students and observers of social welfare, and yet it was our experience with mothers' aid that assistance was often denied to applicants because they were considered unsuitable individuals or were maintaining an unfit home and that the very aid provided was often insufficient for the maintenance of suitable and efficient homes.

In addition to the factors in the administration of the various mothers' aid programs already mentioned, one other has unusual significance for us in this discussion. The number of recipients of mothers' aid, even in States that were granting aid on a State-wide basis, was often relatively small compared with the number of applicants apparently eligible for the assistance by any test. Long waiting lists were the rule in such localities or awards of necessity were spread thin to allow for a more extensive distribution.

Aid to dependent children, an extension of mothers' aid, to be sure, has come into a troubled world disturbed by the failure of society to accept and deal with its responsibility in the past. And aid to dependent children is often, too often, held up as the panacea for all problems of the dependent child and criticized if it does not solve within a short space of months those maladjustments that have been developing over decades.

It is interesting but disheartening to read case record after case record and observe the disintegration of the family following the death of the wage earner. Should we not as citizens feel a profound sense of social guilt when we see a family, deprived of its source of income by death, forced to turn to begging or stealing for its livelihood? And what has been the reaction of the community to such a situation? We can find it in many of the State laws governing the granting of aid to dependent children in which will be found words like these: "The child or children must be residing in a suitable family home, with an adult who is fit"—yes, the word "fit" is often used—"to raise that child." What are we saying in these laws? Are we not saying, in localities where we have made little or no provision in the past for the maintenance of the health and decency of dependent children, and often their equally dependent parent or parents, that even though their needs may have been long-lived—may have developed not this year or the preceding year but perhaps 5 or 10 years before—that family must somehow have maintained efficient and moral standards?

Does not a consideration of the mothers' aid laws therefore have something more than historical significance for us in explaining how we have come in 1938 to an almost universal acceptance of the social-security program in the United States? Does it not also indicate that if aid to dependent children is to make any lasting and permanent improvement in the condition of child life in the country, it must devote itself and its resources not only to preventing and ameliorating economic want and human maladjustment, but also to rehabilitating family life, which has come to be accepted as the highest and finest product of civilization? Social workers are traditionally vocal when they are on the old familiar ground of case material, and the family situations that have been brought to light by aid to dependent children, illustrative of this point, are legion.

In a State, a day's journey from our meeting place, resides a family of a mother and four children. Unfortunately for this family the application for aid to dependent children was made before the local staff, learning on the job, had come to understand and accept the philosophy of the program they were so conscientiously trying to administer. The investigation brought to light the fact that a notorious bootlegger of the community was making this home his headquarters, and a frank interview was the result of the mother's demand to know the reason for the rejection of her application. The details of that interview would perhaps as well be left untold, but the summary statement by the worker was, "and so, Mrs. T., your home is not suitable and therefore we cannot grant aid for your dependent children."

It was not until some months later that this case was accepted for assistance when the child-welfare-services case consultant pointed out that there were strong ties of human affection between this mother and her children and that in spite of the small and irregular pay checks coming into the home since the death of the husband, the home showed, not signs of neglect, but care and attention. It was consoling to realize that while the aid to dependent children law stated that the home must be suitable, that phrase could be interpreted to mean "in the future." Thus the question, "Is this a suitable family home?" has come to have a companion question, "Can the conditions in the home be made more suitable with aid for the children?"

Certainly we, as a group of social workers, are interested in seeing that every child has the advantage of a suitable family home under the care and guidance of a fit parent or adult, but we are learning, sometimes painfully and sometimes slowly, that the way to accomplish that end is not by rejecting at intake or after an investigation an applicant for aid whose home life in the past may have left much to be desired. Rather are we learning that the solution rests either in working out some substitute form of care if rehabilitation of the home is impossible or in giving to that home, along with adequate assistance, intelligent case-work service adapted to the requirements of the family.

What constitutes a suitable home and what of the factors that make for unsuitability? A relative term, it has been observed that it is not uncommon to find a chronic physical condition constituting the difference. Can we absolve ourselves from all responsibility to the mother deemed unfit in a home called unsuitable until we have determined not only the causative factors for this condition but until we have exhausted every available resource to help correct such a situation? In short, are we not saying that it is the responsibility of those charged with the administration of the various programs of aid to dependent children in our States to take the rigid framework of the statutes governing those programs and so interweave that framework with broad policy and interpretation that the laws become the flexible vehicles that sound social-work philosophy demands in any program of social welfare? In the light of this concept, how arbitrary may we be in saying that we will not grant assistance if there is an income in a particular family from an older son or daughter? What right have we to say that that child shall not marry until the next child in the family is able to take his place as a breadwinner?

To be sure, the program of aid to dependent children must have limitations—limitations of law and limitations of policy—but is it not sound thinking to say that these limitations should be as few as possible in the service of the dependent child, for whose needs the Federal and the State laws were passed? True, the aid to dependent children law has been heralded as a progressive step toward a more inclusive program of child care. It is encouraging that children are now able to establish their own place of legal residence and are not being bound to the wanderings of their parents. It is possible now to grant assistance to fathers of children deprived of the care of their mother so that a housekeeper may be employed to provide at least for the physical needs of the youngsters in the family; for whether the State is a partner of the father or of the mother, the needs of the families are not unlike. Again, it is possible in many States to supplement the earnings of the physically handicapped father when, because of his disability, he cannot hope to care for all of the needs of his family.

In many cases it is not necessary for that father to absent himself forever from his family in order that they may be assisted. While our aid to dependent children laws almost without exception hold that the child must be living with a relative, it has been possible in many States to extend the term relative to include any degree of relationship. Similarly, it is possible to grant aid to children in many States regardless of the length of the absence from the home of the deserting father or mother, or without placing too much significance on whether the disabling condition will be likely to endure for 6 months or 6 years. If, therefore, the law is to prove the progressive step toward this more inclusive program, it will mean that we, as the administrative agents, will have to clear away the entangling underbrush of strict, legalistic impediments by broadening our interpretation to include all groups of children so as to accomplish the far-reaching purposes of the Social Security Act.

Recently one of our workers asked us to make a rule of supplementation. We wanted to be obliging, so we sat down to make the rule; but the more we thought the more we realized that a rule was impossible at that particular point. We have already mentioned two types of situation in which we are able to grant supplementation: In case the wages of an older son or daughter are insufficient or the father is physically handicapped and therefore not able to earn a sufficient amount. I think that worker had in mind the question whether we should give aid to dependent children in case the mother is at work, and I imagine that is a question that has come up in some other States. The answer that we were able to give was that we were not interested, of course, in supplementing unsound industries, and the relationship between unsound industries and an insufficient wage sometimes is a little bit hard to define. But it was possible to say that in some cases the fact that some part-time work, when the mother is able to relieve herself of some of the responsibilities of her home and secure adequate care for her children, may represent the difference to that mother between a complete long-time and unwanted dependency and the feeling that she is in truth making her contribution as an active partner of the State.

What of the other factors making up the total content of the program of aid to dependent children? We have touched on the importance of adequate assistance and of the relationship between inefficient living and inadequate income. To be more specific, we are constantly confronted with the results of inadequate income even in the wage-earning group; and, indeed, the offspring of poverty run the whole gamut of social ills from delinquency to a high disease rate. While inadequate income is thus a serious problem in itself, how much more serious may it become when combined with one or more signs of the family's breakdown.

The limitations of the program of aid to dependent children have prevented the granting of adequate assistance to many families. Whether the limitation on the amount of the award is set by law or whether it is determined by a too-low appropriation, the results in general are the same. In an analysis made by the Social Security Board just a year ago, 12 of the 28 States having approved plans for the administration of aid to dependent children had no law limiting the amount of the award, and 9 had laws in which the amount set by the Federal Social Security Act was specified. Two States, however, set an award as low as $12 for the first child and $8 for each additional child, and at least one State has joined this group since that time. The legal maximums, while greatly limiting the amount of the awards, are probably not the greatest deterrent factor in giving adequate assistance, since in some States allowed by law to make sufficient awards, appropriations have proved totally insufficient to meet the needs. Although it is not always a loud voice, it is a rather constant voice that comes from the tax-paying citizens to spread the assistance thin and extend the aid over a wider area.

Applications for aid to dependent children cannot be put in a pending file to await the removal of some more fortunate family from the assistance rolls. Accidents to the breadwinner will continue to occur and permanent disabling conditions will continue to manifest themselves. If the public purse is exhausted the family as well as society is sure to suffer. As the Governor of a Southern State said recently in speaking of the penal institutions in his State, "The State pays for child welfare whether it gets it or not, and it is much wiser and cheaper to see that it gets it." If the parent or adult receiving aid for dependent children is in truth entering into a partnership with the State, certainly the State's obligation, which is the financial resource making possible this partnership, must be sufficient or the partnership cannot succeed in its stated aim.

The distinction has been made often between those receiving old-age assistance and those receiving aid to dependent children that the former are quite vocal while the latter are a silent group needing a champion. What better champion could the dependent children of this country have than those who are constantly in touch with their problems and who speak with the voice of interpretation of the need for sufficient awards? Large returns for small investments are what Mr. and Mrs. Taxpayer want, and where can we find better illustrative material than in our own field? The battle for adequate funds will be a constant one, because it has been wisely said that for every new service there develops a new need; but both legislative and administrative changes are sure to come from a sane interpretation of the very serious economic and social results of inadequate assistance.

On the other hand, it can be said that it is the legal limitations on aid to dependent children that are placing such a heavy responsibility upon private and other public forms of child welfare at the present time—limitations that cannot be removed by any action other than legislative. Since the Federal act limits the degrees of relationship that may exist between the child and the individuals receiving the assistance, there are no funds available for foster-family care either on a temporary or on a more permanent basis. No assistance may be offered to the physically or mentally handicapped child unless he is able to qualify for assistance on the same basis as other children. It is a very interesting mental exercise to try to explain to the mother of a 17-year-old son with a mental age of 4 or 5 why he is not a dependent child.

In short, the program of aid to dependent children in its content is not the all-inclusive form of assistance that had been anticipated by many individuals nor can even the broadest interpretation always make it so. The redefinitions of other programs of child welfare and their readjustments to the needs of excluded groups are of necessity causing a lag in our war on social maladjustments, and child-welfare services are playing a momentous part in this readjustment. But whether we are working through aid to dependent children, provisions for a broad, adequate, and socially progressive assistance program available for all children coming within the purpose of the law, or whether we are working through child-welfare services to demonstrate what can be accomplished with sound case work and in helping to point up the still unmet needs of children, the challenge presented by the return of the investment that is sure to come makes any amount of effort required seem well worth making in terms of the creation of a better society.

DISCUSSION

The CHAIRMAN. Certainly we have plenty to discuss now. Mrs. Thompson quite courteously did not name the States she was referring to, particularly the one where the unfit mother was told that her home was not suitable. It urges me to tell of a choice nugget that I took out of a case record in a State within 50 miles of Washington. The worker told Mrs. So-and-So that she would not grant aid to dependent children for her illegitimate child because she was afraid that if she did so it would encourage illegitimacy. This is what the worker said: "The mother then said to me very scornfully that there always had been illegitimate children in the world and there always would be, whether anybody looked after them or not." I considered that quite a piece of interpretation on the part of the client to the worker.

We now have discussion of the two topics that have been presented by Miss Hoey and Mrs. Thompson. We will go on to a discussion by Miss Ruth FitzSimons, assistant director, State Department of Social Security, Washington, and member of the Advisory Committee on Community Child-Welfare Services.

Miss FITZSIMONS. I think Miss Hoey has voiced the oft-felt hope and wish of all of us that in the next year or two we shall come around to a concentration on service rather than on assistance. I think that we have been appalled in these first 2 years of our public-assistance programs by the methods of determining eligibility and by the mere machinery of making grants. I believe social workers as a group are optimists, and I think it is well that we are, because it is always just next year or the next year or two that we are going to be able to shift emphasis.

I think that in the States where all of the assistance and service programs have been combined in one department we have had some very interesting opportunities to watch the reactions among members of the staff. In Washington our child-welfare-services program has been favored in that we have made a very definite effort to keep case loads low and to select better-equipped personnel for the child-welfare-services program. We have been able to protect the children's program better than other divisions such as old age and general assistance. Somewhere in the middle, I think the programs of aid to dependent children have come along with somewhat limited loads, in contrast to the general assistance part of the program. I think that in the aid to dependent children program there has been a real reflection of the more careful, more painstaking piece of work that has been possible by a worker at an adjoining desk who is carrying out a distinct service program.

The very fact that in many of the counties, for the first time, the child-welfare-services program is the one which has no eligibility requirements, that a child in a rather well-to-do family is brought to the attention of the service program through school or even through the court has been a stimulus and a recognition of service entirely apart from assistance needs. We hope in the next year or two, Miss Hoey, to carry over even into our program of aid to dependent children some of the finer service work, some of the careful analysis and interpretation to parent, child, and community of what we are doing as a demonstration in the service program. Even though we go only a short way with it, I think that we are seeing definite gains all the way around.

But perhaps we are seeing more tangible things that are troubling us just as much—things that perhaps are not dependent upon the quality and skill of the personnel but upon community resources. I find myself constantly challenged by the very tangible service needed in our families, all of our families, in terms of health care. I presume that the State of Washington is typical of perhaps half the States, and when we went into the broad program 2 years ago only 1 county out of 39 had clinic service; and we still have just 1 county that has anything that could rightfully be recognized as offering general varied clinic care, so that we have tackled that type of service throughout the State as one of the objective things that perhaps we should try to get under way early. We have had everything from the small rural county with a part-time county doctor to a good many counties, perhaps half the State, with free choice of physicians, and in none of them have we had anything like satisfactory service. I think perhaps a good deal has been gained from the fact that at least five or six types of service were being experimented with.

I think our greatest gain has been a recognition of the fact that we just did not know what the health needs of our children were. We wondered whether those receiving aid to dependent children were typical of all of the children in the community and whether their health was any worse; our workers had a sense of responsibility about them. Perhaps we were not thinking about all of the children in the community, and just recently we have attempted, with the State department of health, to make a complete study of the whole group of children receiving aid to dependent children and those in the child-welfare-services program in two or three counties. In order not to single a group out and make it conspicuous, and also in order to have a control group, the department of health through the school nurses and health officers was bringing in about 300 children selected through the schools. In the first county about 300 children were receiving aid to dependent children, so that there will be a group of 600 who this week or next week are being examined. We hope that this piece of research, which at least in our State represents a decided advance in fact finding, will inform us whether the group we are dealing with is a representative cross section of youngsters over the State, whether they do have particular health needs that are being overlooked, and, if so, how serious they are.

I wish that we could outline research projects in the field not only of health but of recreation and special educational needs. It seems to me that until we do, any case-work service for which we may be building up a staff is not going to be able to produce the results that would be possible had we not only a knowledge of our needs for community services but cooperation by our counties, through their welfare councils and otherwise, in attacking the problem of the child that we are interested in from the point of view of all other children in the community who are being handicapped by the same conditions or the same lack of services.

The Chairman. Our next discussant is from West Virginia, Miss Lillian Muhlbach, acting supervisor of the Division of Child Welfare, State Department of Public Assistance.

Miss Muhlbach. There are two problems that are concerning us that are somewhat related to aid to dependent children, but perhaps more related to the integrated public-welfare program that we have in West Virginia. The county departments of public assistance in West Virginia combine the assistance program and most of the other welfare activities in the counties. That is, in addition to aid to dependent children and blind and old-age assistance, these departments are responsible for the supervision of children who are released from the industrial schools on parole, and they are also responsible for foster-home care in the county, and participate to some degree in the crippled-children program, as well as in the adult-rehabilitation program. In other words, it is the pivot on which public assistance is administered. Therefore it is necessary to define the functions of the children's worker in this broad program.

Each children's worker is placed on the staff of the county department of public assistance. We have thought of the children's workers' responsibility as being primarily the care and supervision of children who must be placed away from their own homes. That is our basic case load.

Most of the children who are receiving aid to dependent children or general relief do have poor home conditions, and it is rather difficult to distinguish between the general responsibility of the regular visitor on the staff of the department of public assistance and the responsibility of the children's worker. It is in the area of the children's workers' job that we are finding it necessary now to define relationships a little more strictly than we did at the beginning of the program. The supervision of the children who are returning from the industrial schools to be supervised in their own homes or in foster homes comes also into this area. Under the new welfare law the director of public assistance in the county is the probation officer, and he may delegate that responsibility to any member of his staff. In some counties that responsibility is delegated to the children's worker; in other counties there are probation officers.

In thinking of the children's worker's responsibility in relation to children who return from the industrial schools and need placement in foster homes we have considered that the children's worker should be the one to select the foster home and to supervise the children who are placed there. It is more difficult, however, to determine whose responsibility it should be and who might best be able to serve paroled children who are to remain in their own homes receiving aid to dependent children or general relief.

There is another problem that is very much with us. It is rather difficult to have the local county council think in terms other than of a relief grant, even when a child must be placed in a home that is not his own or in an institution. It is possible to supplement a grant of aid to dependent children for a child in his own home, so that we are hoping that with the philosophy of making the financial assistance in a home more commensurate with the child's needs the foster-home program may also be defined by the child's need away from his home and not in terms of an assistance grant. We are one of the States, I am sorry to say, that have a grant limit of $8 to $12. We hope in time that with an increase of this grant there will be also a change in the attitude toward payments for children who must be cared for away from their own homes.

The child-welfare-services program, through the division of child welfare, is operating in 22 counties of West Virginia through the county children's workers. In the counties without children's workers case consultants offer consultation services. It is hoped that through the stimulus of the division of child welfare there will be a county children's worker on the staff of every local county department and that the consultation services will take the form of more intensive supervision of those children's workers.

The integrated welfare program in the State means that a county department is the only agency in any county to administer social service or to perform anything approaching a case-work service, whether those they serve are recipients of assistance or whether they are children from families who are not recipients of relief. It also means that the children's services are utilized beyond the relief area, and problems from schools and from families who in no other way touch a public program are referred to the children's worker. Consequently the services of the children's worker to those receiving aid to dependent children must be somewhat restricted. This, again, brings us back to the necessity of defining the children's worker's job in terms of services to children away from their own homes and also to those children who present behavior problems or in some instances health problems.

The CHAIRMAN. I wish that we had time this afternoon to talk some more about the adequacy of grants. Some of the discussants have mentioned increasing the maximum grants of $18 for one child and $12 for each additional child. I have been puzzled, and I know that many of you must have been also, about what happens in a situation in which a smaller grant is given by reason of the past standards of living of the family. What happens when the local wage rate and the standard of living of the independent families are exceeded? I always like to hear in a discussion the whole background of the problem of the family budgeting, of home management, of better expenditure of funds, along with the question of adequacy, which is so essential in a program of aid to dependent children.

Our next discussant is Miss Beth Muller, director of child welfare, Arkansas Department of Public Welfare.

Miss MULLER. In asking me to discuss this phase of aid to dependent children, it was suggested that I deal with it in relationship to our experiences in Arkansas. Arkansas has to plead guilty, according to a report from the Social Security Board of last December, to paying the lowest aid to dependent children grant of any State making these grants. It reminds me a bit of a trip that I made out into the hills of Arkansas one day. I met an old woman and asked her how to get to a certain place and she said, "Well, lady, you just keep on going and going, and finally when you can't go any more you know that you are getting there." That is what we are doing in Arkansas; we are going and going, and we hope that we will get nearer our goal, but we are rather nearer the beginning of the going.

There are some circumstances that have put us in this unenviable position. You are talking about the maximum grants of $18 and $12 for which reimbursement from Federal funds is possible under the Social Security Act. We have to look up to see that amount, and we cannot help but envy the States a bit that do have those amounts as a minimum or even as a maximum. According to reports, our average family grant was a little more than $10 a month. Now you know, and we know in Arkansas, that we cannot pretend to tell a mother that we are justifying the giving of that amount for the care of her children.

What are some of the reasons for this? Well, Arkansas is a low-income State and our revenues for the last 4 months have fallen off tremendously, so that even our average of $10 may go down. We are in a position of saying that we cannot pay more than $12 to any one family in the State. The range is from $6 to $12. At the same time, our average for the old-age group has been around $9, so that again you see that those in the older group have an advantage over the mother with young children.

Because of this condition we are faced with some other difficulties. For instance, a group has started very actively agitating in the State to follow the example of Colorado and to have an old-age pension system of $50 for every person over 60 years of age in the State. That sounds like a pipe dream, but it is not so far from reality. Things like that can happen, you know, and that has been one of the results of the great interest that has been created in the pensions for the aged in the State.

Another thing that is happening is that we do have a very large general-assistance group in the State, cared for from State funds. We know that in that group are many of the most serious problems for children. The family that is not yet ready for aid to dependent children, the family that has had sudden catastrophe, the family with temporary illness, the family whose resources are gone for the time being—their needs are met from our State funds. That means that funds that might be used for Federal matching have to be used for that purpose, so that again our children are penalized. Those are some of the conditions that we are meeting now, and we talk about a service level. We are just as interested in a service level of care in Arkansas as you are anywhere else.

Personnel has been one of our serious problems, closely related to these other problems, and you may have been noticing that Arkansas has had its ups and downs in that matter. There was a civil-service law which was operated successfully, and persons had passed the examination for county positions. Then the question was raised whether they were county or State employees, and that went into a long controversy and discussion and finally came up to a friendly suit in the courts of the State. It was decided that these people are State employees and therefore come under the provisions of the civil-service commission. The question has gone to the Supreme Court, and the opinion will be handed down within the next few days. That has held up progress in Arkansas for months, because nobody knew the status of these positions and nothing could be done to be sure whether people were going to stay on in them; yet those in the positions are the ones who are administering aid to dependent children and who are the representatives of the State department of public welfare in the counties. Those situations have held back some of the progress that we might have liked to make.

Now conditions are clearing considerably. A civil-service examination has been given for the workers in the State Child-Welfare Division, and within a short time we will be having our field consultants in child welfare. That sounds as though we were only starting. Let us go back a bit. There are good things in Arkansas as well as problems. In the first place, we do have an excellent law setting up the State Department of Public Welfare, a flexible law, a law that does not make rigid provisions within the act.

The assistance groups—old-age assistance, aid to the blind, aid to dependent children, and general relief—are all under an assistance division in the department of public welfare, which is closely integrated, physically and in organization.

Even though Arkansas is at the foot of the list so far as the financial side goes, we are aware that we are at the foot of the list, and we are hoping that something can be done about it. We realize that our children's program is being penalized for the other programs. Because of the 50-percent reimbursement for old-age assistance and for aid to the blind, and because of the 50-percent reimbursement on the administration cost, people are still agitating for giving more attention to these categories than to the children's end of the program. But in spite of all this, there is a splendid awareness in the State, a splendid eagerness for progress in child welfare, and a splendid opportunity for going on, so that we are hoping that we can keep on going and going until we get nearer to the place where we cannot go any further.

The CHAIRMAN. The last discussant on the program this afternoon is Miss Charlotte Leeper, case-work supervisor of the New Hampshire State Board of Welfare and Relief.

Miss LEEPER. I want to discuss for a few minutes one of the questions raised by Miss Hoey, the problem of transition of emphasis from what a man who wrote me recently called a "widows' rights program" to aid to dependent children. In New Hampshire where we have had a widows' rights program or aid to dependent mothers since 1915 and now have aid to dependent children, the change of emphasis is a very real problem, and it is hard to know how fast we should go or how to measure community progress in the change of thinking, because it does seem almost revolutionary to communities that have accepted since 1915 widows' rights, and the worthy family, and the fact that there is a particular prestige in being a family receiving mothers' aid as compared with general relief.

The mothers' aid law was administered by the Department of Education until 1928, and since that time it has been administered by the State Department of Public Welfare by means of an appropriation made by the legislature to the State. Two workers from the Concord office took care of the aid and service throughout the State. We have now a maximum load of 360 families with 1,000 children, so that you see it has always been a fairly small case load, but the two workers have had too large a case load to give adequate service considering the number of cases and the amount of territory which they must cover.

The child-welfare program of the State prior to the time of the Social Security Act was carried out by four workers who worked out from the State capital to the various sections of the State, providing protective, preventive, and corrective services as well as foster-home care. So with the beginning of the child-welfare services, set up in four rural areas with trained workers who had a fairly small case load, we were able to give to that work and to those areas more adequate child-welfare service than it was possible to obtain in the mothers' aid program.

The mothers' aid worker could call on the child-welfare worker who was going to be fairly near one of her families to help her out on special needs and special problems of the children. Next in providing aid for motherless children, for example, the law says that a housekeeper must be employed at the time the grant is made. The homes were so often on a subsistence or under-subsistence level that it was very difficult to find a housekeeper in those remote rural areas, and it was most difficult to try to find one who would agree to live under those trying conditions. So if the family could not qualify at the time the application was made, we had, under the law, to say that they were ineligible, and that was the last that we heard of them. Now they can be referred to the child-welfare workers, and while it is still one of our problems to solve this question of adequate housekeeping service in motherless families, we have made progress and feel that we have a beginning, at least a point of departure, for expanding our program in that field.

The next problem, which we feel child-welfare services are helping us with, is the community acceptance of our continuing to assist families that to the community no longer appear to be worthy. We had to begin with a change of emphasis on the part of workers on our own staff. Workers who have been administering a program find it difficult to change their thinking, but we have tried to use material that we found in our case records. I quote from one entry made in 1931 by a worker who said: "I recommend that we try this family with $18. I don't believe that it is going to be a worthy family, because she is extravagant with her money, and has been on relief, and therefore a pauper." In January 1938, this entry was made in the record, by the same visitor, incidentally, who made the original one: "I feel this woman has managed better than any case I ever have known. I admire her capacity for stretching pennies."

Then we have the other type of case record, which is more tragic in its significance, and that is an application made in the same year by a family that had been on relief. The worker recommended at that time: "This family can get along on relief comfortably, and we will not consider it for mothers' aid." Reapplication was made in 1937 and 1938. Investigation showed deterioration of the family and the death of a child because of medical neglect. There is rather startling case material in our own office, which we have used first of all with our own staff in clarifying our thinking and in following through on our new program.

We have asked the child-welfare worker in one area to administer the mothers' aid program. In this area we have an added problem in the fact that our appropriation is limited, and in considering continuing cases of mothers whose behavior is somewhat out of the pattern of the community life, or taking on new cases when we have inadequate funds, the community sentiment is "Why let this one wait while you are helping another one that the community feels is unworthy?" We hope that by transferring the mothers' aid cases to this worker who has established herself in a community where cases of neglect and poverty and of delinquency are referred to her, we can build up in the community an identification between the program of aid to dependent children and the needs of children.

On July 1, 1938, our department will start a new program, under new legislation, to administer public assistance together with child-welfare work, and we hope at that time to have workers carry on the preventive and protective work as well as the assistance program. It has been very interesting today to hear of the integration of child welfare with the assistance program. Certainly I feel that in New Hampshire we will bring a richer service to our children if we can correlate the two.

The CHAIRMAN. Well, there you have before you the panorama of problems. I am struck, perhaps because I am so identified with it, with the similarity of the problems with which we are all faced and with the experimental attitude and the gropings for better methods. The comments are now yours. We have about 20 minutes left for general discussion. I want to ask Mr. Carstens, executive director of the Child Welfare League of America, to comment on some of the discussion this afternoon.

Mr. CARSTENS. One question has arisen in my mind that I wish we could have an answer to from the various States: What effect has the $18–$12 rule in the Social Security Act had upon those States that had previously had no limitations or that now in their statutes have no financial limitations for grants? Has it led to the reduction of grants in the States where there was no limitation previously or where there is no limitation whatsoever at the present time?

And then I would like to make a very brief statement. Together with certain others here, I date back to the period when aid to dependent children, then called mothers' aid and various other things, began. It was very interesting that the movement did not begin among social workers. Some of the finest types of social worker at that time resisted the mothers' aid movement very strongly; and that, it seems to me, has a lesson for some of us and ought to have a lesson for all of us. Now, I do feel that there may be certain things that are being done nowadays, in child welfare or in certain other lines, by people whom we are inclined to look askance at, and who may after all contribute something that we ought also to be willing to listen to.

The CHAIRMAN. Will some of the States that have no limit on aid to dependent children grants comment on Mr. Carstens' statement? Mr. Adie, commissioner of social welfare, New York State.

Mr. ADIE. We think of the categories in terms of long-range grants; and we think in terms of home relief, as we call it, in terms of meeting the situations as they arise out of this social order. Now, in New York State we are doing a better family budgetary job on the general relief than we are in the categories. I have become convinced (and I say this not with any pride or with any assertiveness) that we have gone too far in the insistence on categories, and what we need to do is to make John Citizen realize that assistance, on a broad foundation of general assistance, will build a better structure for our client. Furthermore, it will give us a stronger service than if we keep insisting on aid to dependent children, old-age assistance, and the others.

You have justification for all that you are saying here, but there is another side to it. It is our responsibility to see that the care of all becomes the concern of all in a very fundamental way, and not by placing people into pigeonholes and categories. You can talk all of your life about content, but, in my judgment, not until you have the conviction of the philosophy of the matter will we get the service that our clients deserve and must have.

Somebody said today, and I like this, that on the State level they had been ambitious and had gone outside for leaders, but she said, "On the local level we are sticking to local people." I believe that principle to be so fundamental for the future that I would rather wait 10 years for my standards than get them tomorrow by importation; because a fundamental job in social care is to grow our social servants, not to have them always come from outside the social life of the community.

In New York State, with all of the mistakes that we are making and all of the inhibitions that we have, we have no illusions as to what is meant when our public-welfare law says "the care of persons." That means what the local man will interpret it to mean—and if he wants to do a big job he can, and if he wants to do a small job he can. But we have placed the emphasis on general assistance, and we shall continue to do it in our State because we believe with all of the categories, and there are many, the important thing is the integration of the service in terms of need. Fundamentally, in society the broad general-assistance program is the only program that will in the long run prevent us from destroying the family pool. Remember that England showed it to us, and a great many other countries showed it to us. Each time that you emphasize a social service publicly, in terms of a particularization, you have to offset that by a real emphasis of the family pool. The important element is the family and the integrity of the family in terms of a unit of living cooperating together. It is much more interesting to me than this other question. That is why I feel very definitely that the social worker's future is not on the categories but is one projected in terms of service first and assistance in line with the social mores of that community.

The Chairman. I am sure that there must be some challengers of Commissioner Adie's statements or some vigorous backers of his statements, because certainly there is no more controversial subject in the whole field than the points which he has so hastily hit.

Mr. Carstens. I should like to make one additional suggestion to the commissioner, and that is that while a great many of us believe in the general-assistance program, we have seen certain evidences to show that where mothers' aid has been in effect it has aroused the sentiment and the general assistance of the community. Now I am thoroughly in accord with what Mr. Adie said, but I wonder whether in the States where aid averages $10 and upward—after all, we have to recognize that in New York it is in the $40's—something might happen to lift the general assistance when we specialize for a time on the mothers' aid program.

When I was in Massachusetts, and some of these Massachusetts people can tell about it a great deal better than I can, we rewrote the statute that a commission had presented and asked that mothers' aid be administered by the selectmen or the officers of the poor, so as to get it integrated with the general-relief program, but none the less, setting a standard which emphasized mothers' aid. The result, if I am not very badly mistaken, was that it lifted the whole general-relief standard. Now, in New York you had a special board set apart to do that work, and I think that in Massachusetts we had a mixture of the two forms of aid that was really of value to both sides. I wonder, therefore, if there is not some value for a time in working in the direction of specialization of a category.

Mr. Adie. May I just make myself clear? I hope no one will think that I am asking for the abandonment of categorical services now. I tried to say that that cannot be done in all the States at the same time. Whatever our position on the categories is now, we must bear in mind that our goal is family service.

Miss Gordon (Rhode Island). I should hate to say what our rating is on general family relief. It is pathetically low, terribly low, and now that we have the more liberal aid to dependent children law, which lets in certain beneficiaries carefully excluded under mothers' aid, we are in a position where we are going to have a toboggan slide unless we are very careful, because we have now a group of families that have been in this low category, who are eligible under aid to dependent children, and we cannot get an appropriation to meet their needs.

The Chairman. Are there other States that can comment on this question of the relation of the general public-assistance appropriations and their effect on categorical assistance?

Miss Parrott (Maine). I think that in Maine there has been a tendency to think of the Social Security limit as the yardstick to be used in setting grants in the State, and that we are having lower grants than perhaps we did a year ago.

Mr. Carstens. May I ask Miss Parrott whether that is because there was a limit set?

Miss Parrott. It is, because they are going through their list of grants to see how many of them are over the amount, the maximum amount of the Social Security Act, and up until that time they were not conscious of a maximum amount, because the law did not fix it.

Mr. James (Virginia). I represent a State that has just begun to receive the benefits of aid to dependent children under the Social Security Act, and I might say that we are very much concerned about the effect of the new public-assistance features on the limited but now 15-year-old mothers' aid program. We have had a State fund of $1,000,000 for subsidy to the counties and cities for general relief, which we have by bookkeeping kept categorically, but nevertheless it was a general-relief subsidy. During the last few years we have done that. Now both with the use of the small State mothers' aid appropriations and the use of the much larger proportion of the general public-assistance fund, in the mothers' aid cases, we have a State average of $45 for the city cases and $25 for the country cases, or an average of $30 in the mothers' aid cases, or what we might now call the aid to dependent children's cases. We have no idea in the world that under the new program we are going to be able to keep the standard up to that level, although we shall have an opportunity of supplementing those cases out of the general-relief fund, which goes into the new bill at approximately $1,000,000 or whatever it is now. Now, our brain trust down there is addressing itself to the problem that we are going to have, of preserving the status quo, or even improving it under the new program, and it is hopeful that we shall.

Miss Atkinson. I think that there is one more thing that might be said, before we close this meeting, on the discussion of the relationship between aid to dependent children and child-welfare services. I think that you all should know that on June 30, 1937, there remained in the aid to dependent children fund that had been allocated to the Social Security Board, $14,800,000, which had not been distributed to the States, because the States did not have matching funds and therefore did not present demands for the allocation of that money.

Mr. Bane told me the day before yesterday that the estimate for this year is that on June 30, 1938, there will be a $25,000,000 unexpended balance of Federal funds for aid to dependent children. It seems to me that these two figures are very significant. They show us the way that we must go in trying to rally support in the States for more adequate aid to dependent children programs and also that we have some responsibility for doing the thing that Miss Hoey said, namely, letting Congress know that we think it is time that the National Government stopped discriminating against children and at least became willing to reimburse the States on a 50–50 basis as is done for the other two categories.

Monday, April 4—Evening Session

Katharine F. Lenroot, Chief, Children's Bureau, United States Department of Labor, Presiding

Miss Lenroot. In planning this program Miss Atkinson was, I think, very wise in saying that she wanted the emphasis this year to be placed not upon the mechanism of organization, not even upon problems of training and selection of personnel, which are so vital to the work, but upon a consideration of what the program may mean to individual children back in the communities to whose workers you are giving counsel and guidance and for whose services you are planning.

The children who are in neglected homes—in homes where the inadequate relief or the absence of relief may mean real hunger, suffering, and deprivation—the children who are in trouble in school, who come in conflict with the law, who are bewildered and frustrated by the fact that they don't seem to keep up with the other children—they are the children who have the countless difficulties which bring them to the attention of the workers in the communities.

And so we have asked two persons to contribute to this evening's program who are unusually able to bring to us a message of significance as to what we are trying to accomplish in human terms.

I have very great pleasure in presenting to you as our first speaker the Honorable David C. Adie, commissioner of welfare of the State of New York.

Some Aspects of Child-Welfare Services

By Hon. David C. Adie, *Commissioner, New York State Department of Social Welfare*

Somebody was good enough to suggest a general line of approach for me tonight in asking me to discuss some very obvious aspects of child-welfare service. I am glad to do that because we certainly do need to begin at a very early date to think outside of the relief program; not that we might get away from the relief program but that we might add to it.

Let no one think that, in any remarks I have to make tonight, there is any less insistence upon standards of work. In the insistence on it I believe, but I also believe, as I think everyone else does, that the key to the whole situation administratively is personnel. With a good personnel we can accomplish much, and with a poor personnel we can have all kinds of difficulties.

Like most people I have been impressed with the fact that we have been for many years very definitely under the tyranny of relief itself. We have concentrated on the mere gathering up of great numbers of people who had to be rapidly succored, who had to be thought of in terms of needs in the first place, and to whose needs there had to be added other services. These facts have colored our thinking. They have been compelling in their nature, and as a result I think we have not stopped long enough to ask ourselves what may be implied in some of the other aspects of the problem.

Tonight, therefore, I am going to direct my thinking to some very obvious things, nothing new, and try to restate, to reemphasize, as it were, some of the things for which this conference particularly stands tonight.

I do that because I am becoming more and more convinced that fundamental to this whole national program is not so much the question of raising tax monies to care for people as the need for finding a means of getting an additional method of redistributing the national income; that what we are engaged upon today is not merely the care of millions of people in a work program, a relief program, or any of the other programs, but the more adequate spreading out of the surplus that society has. This is done not solely for the care of the client but for the underpinnings of the whole economic order and the structure in which we live.

I have come at this question, as most of us do, from a general casework basis. I take it that the family case worker is still in that relationship to a family; that consultative and definitely advisory relationship which, however arduous it may be in its nature, nevertheless is a general continuing policy.

The crises that we meet in the family field are never so real as they appear to be. When you move over, however, into the children's field, it seems to me that you are in a very different relationship, in that the worker in the child-welfare field has a more authoritative relationship to the child. It is because of that fact that I, among others, have been stressing the need in our communities of raising standards of workmanship among the child-caring agencies higher even than we are trying to get into our public-assistance program. I do not mean by that to cast any disparagement upon any of us engaged in the public-assistance work, but I am trying to say that you can condition a person more easily to the one than you can to the other.

The child-welfare worker, as I see it, must have that relationship by which he skillfully adapts himself to the task of establishing environments, of creating definite associations, of modifying a culture in which the child has to develop. That definite relationship not only is sharp and defined but sets him apart with a need for developing new skills and for developing more definitely specialized skills than some of the rest of us are called upon to develop in our jobs.

Both approaches have the same type of objectives. Both are struggling for the conservation and development of personality; and both are struggling for the preservation and the reconditioning, and necessarily the reconstruction, of the family life, all the while accepting the family unit as a basis of the operation.

While we have this common objective, I want to emphasize some other facts. There is a need, it seems to me, to realize in the very first instance that mere knowledge about a child does not lead to an understanding of the child. We can develop all kinds of systems for acquiring knowledge—statistical knowledge and data on the several fields, which might be far-flung and very exhaustive in its nature—but that by no means enables us to come to the job of understanding a child.

It is comparatively easy, it seems to me, to secure that type of information. What is difficult is to get our service to such a point that we can see the child's experience through the eyes of the child and that we become intensely sensitive to what life has done to the child—to try to catch that experience in childlike terms.

I have a feeling that a child is the hardest thing in the world to see. If you do not believe that, all you need to do is look at the average educational structure and see how few people educated in the pedagogical methodology, with all of the advantages of the modern educational system, have the faculty of seeing the child in relation to the development of personality. We social workers must not make that mistake. We must be able to see children, and we must be able to get away from that other attitude which is so characteristic of the adult. One of the great things that we have to learn, although it seems to be a very obvious thing, is that gathering this type of information about children ought not to enable us to side-step the task of attempting to understand them.

We have to develop our programs in terms of reality and not in terms of ideology. We must get away from thinking that we must establish the environment in which children shall grow, that we know what a suitable home is, that we know what family life should be, and that by going through a school of social work or from experience we have acquired some skills in social-work practices by means of which we can determine the validity of the home. That, it seems to me, is one of the most unrealistic approaches that we can develop—purely an approach of expediency.

It was an old Jesuit who once said that at 20 a man was governed by his desires, at 30 by expediency, and at 40 by reason. Somehow or other we social workers must project ourselves to 40 as quickly as we can and apply ourselves to the work with reason.

We are too much concerned, it seems to me, with material factors, with homes conditioned in terms of measurement. If there is a sun parlor, some cushions in the living room, something in the kitchen, and this, that, and the other thing around the place, we consider that makes a desirable substitute home. Well, does it? You and I know that in all too many cases the child in a so-called perfect material substitute home cannot retain the contact with his parents because of the fact that psychologically the parents and the foster parents cannot meet on the same ground by the very virtue of the material advantages that now surround the child in the substitute home. We must realize that if we are going to have perfect substitute homes for our children we must have those things in them which relate themselves to the background in which the child finds his experience.

The whole child program, it seems to me, has to be viewed in that way, and I am simply indicating some of these things to you tonight. I think the first responsibility of every child-caring institution follows at that point—the preservation of the family in itself. I think we must realize that we have gone around a circle, and we might well say to ourselves, "Let's call it a day."

When we first began, we grouped the children with the blind and the poor and the others. That, of course, did not work. Then we built institutions which have not been satisfactory to everyone. Now we have been worshiping too long at the shrine of foster homes. We must move back to the realistic thing, the child's own home. We must begin to realize that, just as the real-estate people have sold us this system of "own your own home," we have to start philosophically to say to the child, "Go back to your home." We have to have a sort of "own your own home" development.

In New York State we had a judge who was breaking up a trio of children and placing them in foster homes because the children should not be brought up in the manner in which they had been living. What we forgot, of course, was that 3 years before we had done exactly the same thing with two other children in that same family because the mother was fond of dancing every Saturday night and the father of the children had some rough companions and occasionally got drunk. So this judge proceeded to make possible the continuation of a futile policy.

What has society done to that mother? To that father with his desire for rough company? I am beginning to feel that it is overlooking the fact that our clients have rights—and very real rights. Sometimes they exercise some of those rights that we do not like, but that is not the point. They are their rights. Society can use police measures on some of these; but we have to realize that that is the atmosphere in which we are going to operate whether we like it or not.

The program that is to come must, then, be based on an attempt to be very realistic. It is not a question of the institution versus the foster home. It is a question of mobilizing all of the resources in the community, based on an understanding of the child, and the skill with which we can use the means at our disposal.

The institution—not the child—must bend; the foster home—not the child—must bend; and the social worker—not the child—must bend. We have all got to do our adjusting to the child.

It is a very strange process. We have all been so busy making children adjust themselves to the adult; whereas, although the adults are supposed to be mature and intelligent, very little of this adjustment responsibility is placed on them. I think, too, very little of it has been expected from us as a profession. To be perfectly frank about it, I think that we have suffered from an undue appreciation of ourselves in relation to children. Now, we are never going to see the child in this category unless, as I say, we are realistic about it.

I am pleading tonight for myself and for you to realize that our task is just opening up and that, with all of the skills that come to us from the advances in child care, these are merely tools in the last analysis. It is your job and my job to realize that we have been set apart in society as tool tenders and tool users; and, if we do not have that attitude to our job in realism and in terms of the ideal at the same time, with all our training we are not going to be very effective.

You cannot begin to say that the job is to deal with personalities and to allow personalities to be as free as possible until you begin to translate that wish of ours, that concept of ourselves in terms of the spiritual or the spiritualization of our own job.

It is not seeing it in terms of numbers and in terms of material needs, but seeing it in terms of that which is so sacred to us that it has been termed the possessing of a reverence for life. It is seeing that our programs, whatever they are, are motivated not by the amount of money, not by the number of institutions, and not by the number of free homes or other kinds of homes that are at our disposal, but by the workers dedicating themselves to the task of becoming responsible for holding themselves sufficiently in check to allow that personality that we claim to believe in to have a chance to take wings unto itself and fly.

It is on that basis that it seems to me our programs should develop. We should be motivated by the philosophy, by the compulsion, and by the concern which we have for this sacred thing we call a personality. If we do that, we can go and take that back to our communities and use it in terms of more money to the legislatures and more money from our constituencies. That is not always easy, but it is possible.

Dr. Plant will be interested to know that not so long ago I went to the legislature to try to get a psychiatrist for one of our institutions. The committee went down the budget line by line very slowly and suddenly stopped at that word.

An official said to me, "What is that?"

"Oh," I said, "that is a psychiatrist."

"Well," he said, "what is that?"

I tried to put into plain English what that was. He just listened to me very patiently and then said, "Oh, well, out with that."

Now, that was because I had not convinced that man that there was a real need and real validity in the application of intelligence and affection to the reconditioning of delinquent children. The fault did not lie with the legislator, the fault lay with the interpreter.

So I plead with you, and I plead with myself, tonight, to think this job through, not in terms of processes but in terms of real concern for people who are in unadjusted positions and under adverse conditions, who, unless they become dependent upon our seeing the matter fairly and squarely and in a related manner, have really no hope of gaining a growth or development under any governmental plan or governmental system.

Miss Lenroot. Mr. Adie has brought us back to reality in a very vivid way, back to the question of a child's own home and the possibilities for the development of the child's personality within that home.

I know that we are thinking tonight of the conditions confronting so many homes in this land of ours, of the shadows which poverty, and unemployment, and sickness bring, and the thwarting of personalities which result from those shadows, and the tragedies into which they often materialize.

It gives me more pleasure, I think, to introduce the next speaker, than to introduce any speaker that I know in this country. I had the great privilege of working with him, at the time of the White House Conference on Child Health and Protection, when we were formulating that report on the delinquent child, and he used to say that I ran a thermometer over every line of the manuscript, and when it registered about seventy I cut it out. I think that he felt great freedom in working on the book which he published this year because he did not have to have it subjected to any such process.

But we are tremendously privileged to have Dr. Plant associated with us in this movement. He always responds whenever he possibly can. He has gone out into the Middle West to give counsel and advice in the development of one of the programs there. He is always a great tower of strength to all who know him and have the privilege of hearing him.

Positive Programs of Child Welfare

By **James S. Plant, M. D.**, *Director, Essex County, N. J., Juvenile Clinic*

Dividing our entire project into three parts, let us see whether we can define for ourselves certain objectives for the child with whom we work, for ourselves, the workers, and for the program in which we are working.

In attempting to define certain objectives for the lives of these children, I could say nothing more to you than Commissioner Adie has already said, except to try to fill in this picture of what we are after and what we are striving for. This does not mean in any sense that you are to accept the particular points that I am going to make, but that you are to try to build an approach yourselves, which is one of setting up a picture of this personality we would develop or these rights of the child. One has to do that, because in our work you and I have dealt too much with negatives. We must not go on simply trying to get a child out of such and such a situation. This is not true in the field of physical health, is it? Health is not just the absence of disease. There is something more positive about it. In this whole field of the social development of the child and in the development of his personality we must think about the things that we want to develop rather than the things that we want to get rid of.

There are five things, I think, that should be the right of each child, as he awakes tomorrow morning, to have as possibilities during the day. That is, just as you know that tomorrow, from a physical point of view, he needs a certain amount of sunshine and a certain amount of vitamins, is it not possible that there are similarly five things in the mental field which the child needs? And if there are these things, then these must be our goals, the things that we must never forget and the things that we must think of providing for each child as he comes to us. Always, of course, we have to deal with the negative things, and always, of course, we have to get the child out of one or another scrape; but we must work toward this more positive goal.

I think that when the child wakes up tomorrow morning, or indeed when any one of us wakes up tomorrow morning, perhaps, first of all, he will look for a thing which I will call "security." I am going to use the term "security," if I may, in a rather special sense tonight.

To illustrate, let us go back to the Covenant of the Old Testament, in which God said to Abraham that in return for certain things every person who is born a Jew would be a chosen person. God did not say that that person needed to be tall or handsome, and He did not even say that he needed to have a high I. Q., or that he needed to have any special social or intellectual or emotional qualifications, but rather that each person born in a certain family by that fact would have a certain place. Nor did God say to Abraham that it was only those people who were at that time alive. A person 200 or 2,000 or 20,000 years from that time born in a certain family would be a chosen person. That is a position which a person gets because of who he is. I am glad that you have had Commissioner Adie's statement earlier as to the need of getting back to the own family of the child. I am quite sure that it is within the child's own family and within that family alone that the child gets this security—because of who he is.

To put it another way: Any one of you might talk to me about your mother; you might say that you know more beautiful women than your mother; you might say that you know more intelligent women than your mother; you might say that you know better cooks than your mother; but then each of you would say, "But she is my mother." You see, she has a place because of who she is.

Many of you have heard me tell a story that I cannot forget. I have to tell it again because it stays with me through all of my work. It is the story of a little 12-year-old girl who had been adopted into a family that had everything that a family could give to a child—wealth, affection, and all that sort of thing. Of course, the neighbors and relatives had told her all about what poor parents her own were and how they had run away from her. When we were talking about the adopting parents she said that she cared more for them than she did for her own parents and that she accepted them as her own. She never thought about her own parents. We went on talking about some other things and later on she said that she did not always go to sleep immediately when she went to bed. "What do you think about then?" She said, "I wonder always what they used to call me." You see—here is the deep need of the child to know who she really is. The place a person has because of belonging to a certain family, an unassailable place that a person has because of who he is, is of vital importance.

From a practical point of view, from the point of view of our programs, we must go on with our institutions. And, as has been said to you, we must go on with foster-home care because we have to. But we must fight every minute for the preservation of family life because there is something in family life which is given to the child that nothing else can give to it—this unassailable place because of who the child is. We get the same thing, I am very sure, a great many of us, in our religious life, in which you notice that again we use this family pattern. God is the Father and we are His children. Here again, God does not ask us where we live or how much money we have or how we are getting along in school. The mere fact that we are His people gives us a place, this belongingness that we have because of who we are. I could say to you, I think, that the development of a rich religious life for each child is again a deep necessity. I do not say it, because, of course, here is something that comes up from within the child, something over which we have so little external control.

The second thing that I would look for tomorrow morning for each one of these children is what I would call a certain degree of extroversion. Without trying to be too scientific about it or going into all of the minute intricacies, you, I am sure, know the difference between the extrovert and the introvert—the bouncy, expressive sort of person and the one who has all the drives the extrovert has but who is working them out within himself.

In our group we feel that a mild degree of extroversion is far more healthy and normal than is introversion. It is better that one live in the world that is than in the one he wishes existed. But the extrovert has a hard time of it. For instance, if you go into your nearest schoolroom and ask the teacher to name her three worst problems, the three most difficult children in the room, she will name three extroverts. They are too bouncy—too sudden-about-the-house—for the kind of civilization in which we live where everybody is huddled together.

You see this problem very nicely in marriage, of course. When two introverts marry, the marriage often will not go along well, because there is not in the shut-in personalities of these individuals the freedom of give and take that is so necessary in that sort of venture. The introvert and extrovert in marrying get along fairly comfortably. When you have two extroverts marrying, well, you do not call that a family—that is a zoo.

We are inclined to let these things pass by rather rapidly but you must not do so. Give plenty of thought to the fact that the extrovert is constantly being punished in the culture in which we live. He is in trouble in the family, he is the one who gets into court, he is the one who makes trouble in school. Everywhere he dramatizes and does something about the problems that are around him—he is the one who gets into difficulties.

I have the feeling that not only must we provide for children the opportunity to be extroverts but that we have a tremendous task in interpreting that sort of expression to society so that society understands instead of merely punishing these individuals.

Could I give this illustration: I was asked a month or so ago to see a boy in the seventh grade of school. He was a pest, an awful nuisance, just the sore thumb of the group. I did as I very often like to do in these situations—went to sit in the back of the room for a while just to watch the situation. The teacher was going over something about the surrender of Cornwallis, and I thought that she was doing it correctly. This teacher, from the point of view of an intellectual task, was doing a good job and apparently a correct job; but she was also doing something that I could liken, I think, to nothing more aptly than a person going around a field with an electric flashlight. First, she worked with two children here and then with three over there, and then with two here, with no ability to bring this whole room together and make this whole room operate as a total group. I had not been there 10 minutes before I saw six individuals who, to my way of thing, were far worse problems than the boy I had been asked to see. They were just lumps of dough—sitting there doing nothing. My "patient"was merrily and busily calling attention to the fact that the teacher was doing a poor job. You may be interested to know that already there has been a very marked change in this teacher's mode of teaching. Why? Because of this extrovert. You see, if it had not been for him, if he had been a lump of dough like the rest of them, she would still be doing a poor job with that whole room full of kids.

From a practical point of view, this means for our children (and I talk very much more to city workers now than to rural workers) the constant opportunity to handle or touch reality, and it means, in the building up of the child's play life, the development in the earlier years of opportunities to face the world as it really is.

Let us not go to the limits that we went earlier in my own profession, when we said that any sort of introversion and any sort of daydreaming represented something that was definitely abnormal. We have to daydream. Certainly there is no one in this room who does not have to go to the world that we wish existed, the world that we can dream about, as some kind of surcease from the things that happen to us during the day and from the things that happen to our group during the day, the things that we just simply cannot afford to believe will go on always. We have to go, and our children have to go, to these daydreams, but for the most part we must foster for the children (and this is a job that demands a great deal of community interpretation) a program that means that they are living in the world as it is rather than just the world that they wish existed.

You are up against two troubles here. One of them, as I said, is that society does not like extroverts, and the other is that for the individual introversion represents, of course, a much more pleasant sort of world than does extroversion. You remember the daydream you used to have when you went out on the back porch and thought about dying—how sorry the family would be, and what a long funeral there would be! There was nobody who said, "Well, thank the Lord, she is gone." We always in our daydreams have a happy ending; we conquer and win and have things come out just as they should. So you have here a dual problem. The first is that of interpreting to society, to the school, and to the people with whom you are working this need of the child to express himself, the fact that the extrovert is trying in some way to solve a certain problem, and that that is the more healthy adjustment than quietly accepting the problem and not trying to escape. The second is that introversion offers so much to the child that you cannot kid him out of it, you cannot drive him out of it, but you have to coax him into the world of extroversion through making reality, at least for a time, a pleasant experience.

I think, in the third place, that we would look for something tomorrow that is what one might call a healthy adjustment to the group. I cannot explain this in any better way, perhaps, than by asking each of you to think of yourselves somewhat dramatically in the following situation: Suppose that you wake up tomorrow morning with a pain in your abdomen. You will feel disturbed about this pain, partly because it hurts, but also because you do not know what is the matter. You will go to the doctor and he will tell you, after appropriate prodding and questions, that you have appendicitis. It is interesting that you will immediately feel considerably relieved. You will have found that you have something that everybody else has, something that is quite socially acceptable, something that is known, something that makes you belong in a large group. The doctor has made you like everybody else. Then if the doctor is properly persuasive and you go to the hospital to have your appendix out and convalesce, it is similarly interesting that before you go home you will want the doctor to tell you that your appendix was the longest one he ever saw, or the shortest, or the hardest to get out, or the reddest. You do not care what the factor is as long as he has made you different from anybody else. That is what I call the paradox of life—the need that each of us has to be lost in a group, to be like other people, to be regimented—not to be different—and at the same time to be individual, to be odd and different. You never see these two drives teased out and separated. They appear often in the same sentence. You see the same thing beautifully in that most wonderful of psychiatric ventures—the buying of a hat. This particular event is preceded by some weeks of watching the papers and magazines and people to see "what they are wearing." But the matter is not settled then because when you go into the store you find that you must not buy a hat "that you are going to see on six people the minute you step out of the door."

I could give many examples of this sort of thing. Two come to mind. One is the disturbance of the social worker in these days of budgets and relief over the families' spending money for some unnecessary or foolish thing. We so often forget that in the tremendous regimentation that is going on today we are failing to meet the need of people to be different—to spend some money foolishly—not because it is a foolish expenditure but because it is a different expenditure. Then also you see the same problem on its opposite side, in the matter of the schools. The older school was too regimented, but I think that many of the modern schools have gone too far in the other direction. They are failing to realize that most of us have to be lost in a group, to be regimented, to get strength precisely from this matter of being lost in the group.

In our planning for the child in his games and in his life, we must provide largely those situations in which he has the same experiences as others, in which he is the follower, in which he is a part of the group. And we must equally provide for each child some little corner of his life in which he is the leader, in which he is different from anyone else. You see, I am not talking about anything other than the need of a hobby.

The fourth thing that we would look for tomorrow morning would be what I would call "integration." You can use this term in a number of different ways. This evening I am thinking of it in the sense of a certain wholeness. Perhaps I could explain this in the following way.

We understand the problem of weaning in the physical field. We recognize that when a child is born he is absolutely dependent upon the mother and that then by 5 or 6 he must get to the place where he can eat almost anything. We similarly know something about the problem of emotional weaning. We note that here again the child is dependent upon the parents to begin with, whereas at 18 or 19 or 20 he must still love his parents but must not be dependent upon them. This whole matter of emotional maturity has been very much talked about in the last few years. What I think very few people understand is that parents have to be emotionally weaned from their children quite as much as children have to be weaned from their parents. Parents, as I see them, seem to resent this fact that weaning must go on all over again after one has grown up. What I mean by integration here is this sort of wholeness of one's life that means that he is not dependent upon the others around him.

I am not talking about being a hermit. I am trying to say that for the child, and indeed for yourself or myself, it is much better that one's house be built in the midst of other houses, because this means a richer and more complete sort of life; but that this house must be built so that if the other houses tumble down it still will stand.

In the area in which I work we have provided so much for the children and have scheduled their lives so much and have given them so much of external resources, that we have not built up these internal strengths that I am trying to cover under the term "integration." We do not have children who, when put on their own, know how to live with themselves, and I am sure that this is a fundamental necessity.

Finally, I think that tomorrow morning we will hope that the day will provide for us or for the child a certain amount of success. I am not sure that you will agree with my definition of success. It is the only one that seems to me to fit what I actually see at the clinic. I am sure that successful people are not necessarily people with money, nor those with possessions, nor those who are growing or developing as I would have thought that successful people should. I am quite sure that success comes to a person when he is in a situation where "nobody else will do." This is the only way that I can explain why Mrs. Macaroni, with 10 or 12 children, no money, nothing at all but hard work day in and day out, trudging alone through life, shows some sort of release from the problem of happiness that I do not see in Mrs. Astorbilt, who lives in a very large house and has all sorts of servants about. I am quite sure that Mrs. Macaroni often has an experience that the other woman is striving desperately for—the experience of being needed by other people, the experience once a day or 20 times a day of being turned to because "nobody else will do."

So far as the child is concerned, I think that this means for us, again, very much less scheduling and planning than we are doing in this country. It means very much more a chance for the child to have responsibility, to be turned to for real jobs, to have experiences in which he can take hold of life himself.

Some of you have seen this in the problem of the runaway child. There are many times when the child, at least in my area, goes on this sort of venture because here he has responsibility. When you are a runaway you have to find your own food and your own place to sleep. There are many tragic things that happen to runaways, and I am not trying to present this as a good pattern for children to follow. I use it only as an example of the need on the part of many children to experience this thing that I have called success. It should point to us the need in our programs for giving to the child a real place that is his own, a real job that is his own, situations in which "nobody else will do."

Just to recapitulate: In what we plan for the child, let us think of those things we want him to have instead of those things we want him to be rid of.

Here first of all would be our joy in his having security in his own family. This will raise havoc with your work. It will mean that often when you know just what Johnny needs and just what should be done with him, the parents' only response to you will be, "But he is Johnny." It seems to me that we must foster just that sort of attitude, regardless of how much trouble it makes for us, because it means that the boy has an assured place in his relationships with other people.

Then we must work for those things that will constantly lead toward the development or the preservation of a certain degree of extroversion in children. This is difficult because every advancing civilization represents an introverting process. All young civilizations are extroverted. The Greeks in the early part of their civilization captured the woman they loved, carried her off, went and killed people because of her. Then when they came to their golden age, to a higher and higher civilization, they made marble heroes instead of flesh-and-blood heroes. Each civilization as it advances similarly replaces reality with symbols. Finally it comes to its golden age and then you notice that it decays. If we are to preserve the strength of our group, we must be forever interpreting to the community the strength that is represented in the extroverted child.

We must try to develop for the child a pattern of life in which for the large part he is lost in the group, and yet one in which he has a corner in which he is the leader or is different. It is only then that the child who is behind in his school work, who is not making a good social adjustment, who is lost in every other part of his life, says, "Well, wait till they come to checkers." That is the place that is his own, that makes him an individual, that gives him leadership, that allows him to meet every sort of buffeting with sweetness and a sense of adequacy.

And then we must plan to develop for the child, as best we can, the ability to live by himself, the ability to find within himself resources of richness and happiness in life.

And finally we must develop for the child those opportunities to have experience which I have called "successful" experiences.

I am not going to talk very long about your own objectives, but I should like to say just two things about them.

The first of these is an objective that has a good deal to do with that cynical, beaten, bitter attitude that we see expressed in so many adults, of "Oh, well, what's the use?" You all know this sort of hardened picture of defeat. To me it represents the most subtle enemy of the social worker. I am very sure that this attitude most frequently develops from having set goals and objectives that are too high.

It is dangerous to talk about having goals that are not too high, and yet I am sure that the matter of plodding along with an eye to a goal that is attainable gives us those experiences in triumph that are absolutely necessary. It is when you build standards for yourself that are impossible that your spirit breaks. I often feel in my own work—and this again is perhaps a dangerous thing to say—that the first approach that it is wise to make to a problem is not in terms of measuring those things that we can do for the child but in first separating out those things that we cannot do for him. It seems to me that it is so often necessary for us to find first those stone walls that will only break our spirits.

And the second thing, in the matter of your own objectives, has to do with the way of measuring your work. I should like to see social workers more and more measuring their work in terms of themselves—how much they have grown, how much more life means to them than it did last year. I say this because I am quite sure that the children with whom you work do not grow any more than you do. Oh, yes, you can set out at the end of the year a very handsome statistical table of the calls that you have made, the number of children you have had in your care, the clothes that you have provided for them, the job placements you have made. But I am sure that if life is not richer for you, if you do not have stronger faith in those things in which you had faith, if you do not know now better than you did a year ago what you are after in life, those things that you are striving for—then I am sure that your clients have not done much real developing. In every other human relationship, in every friendship, we know that both people grow. We must see that this holds for the social worker-client relationship.

And then could I say to you just two little things about the program.

First, you must use this program to teach your communities. It is your delinquents that have built your playgrounds. It is your truants that have changed your school curriculum. Go anywhere you want to, and you will see that it is the rebel who dramatizes life. If you go back to your communities just to work with the rebel you are doing only half the job. You must constantly be interpreting to the community what that boy or what that girl is trying to do. When you do that you will become real teachers. It is the only way that I can see of escaping the present plight of most social workers, that of being glorified street sweepers, forever just sweeping up the debris of life.

I like to think here of one of the oldest prophecies that man has had: "The stone that the builders reject will be made the headstone of the corner." Of course, a great many people feel that this prophecy was fulfilled some 2,000 years ago. But we can fulfill it today just as truly as when it was first made. In fact, that seems to me to be the great challenge of our work—that we interpret to society its weaknesses, its stresses and tensions, through what the delinquent, the truant, the breakdown tell us. When once you start to use this child—this problem child—to teach your community what it is doing to all of these people, to teach your community the problems of the child, then indeed do you make the stone that we reject the headstone of a new social philosophy. These children pay a terrible price, but you can make that sacrifice worth while if you teach your community what it is doing to all of its children. There comes in this way out of your program the basis of teaching our society a new sort of justice for all children and for all people.

Lots of times I wonder, when I am sitting alone with a youngster in the office, what is the use of doing this work with John and Mary and Helen when there seem to be so many large and engulfing issues sweeping over the whole world. Why keep at this picayune sort of individual business when fear and hatred and war are about to engulf us all? I suppose that many times the same question occurs to you.

My own answer—perhaps it is not a very good one—is that perhaps we are one of the few groups that remain truly democratic, in that we are still pinning our faith on the development of single individuals. So I ask you to preserve this faith, to preserve this vestige of democratic philosophy in a world that would seem to sweep it all aside in great mass movements.

That is all that I have to say. It has been hard to put into words what I feel about your relationships to the program. I could not do any better here than to quote a bit of Chinese poetry.

The poet Wang-Wei was asked what he liked best in life. He answered:

I am old,
Nothing interests me now.
Moreover, I am not very intelligent
And my ideas
Have never traveled further than my feet.
I know only my forest,
To which I always come back.
You ask me
What is the supreme happiness here below?
It is listening to the song of a little girl
As she goes on down the road,
After having asked me the way.

Tuesday, April 5—Morning Session

MENTAL-HYGIENE PROBLEMS AND SERVICES IN RURAL COMMUNITIES

Cheney C. Jones, Superintendent, The New England Home for Little Wanderers, Boston, and Member of the Advisory Committee on Community Child-Welfare Services, Presiding

The CHAIRMAN. As I left my office Saturday I picked up a book left on my desk and on the train I fell to reading it. I think it would be a good idea for all of us to look at it. The book is "A Pediatrician in Search of Mental Hygiene," by Dr. Bronson Crothers, assistant professor of pediatrics at the Harvard Medical School and visiting physician to the Children's Hospital in Boston. It is published by the Commonwealth Fund. I have not read the entire book, but became much interested as I browsed in it. The title is intriguing. In approaching this meeting this morning one might think of a book entitled "A Farmer in Search of Mental Hygiene." Any one of us might consider himself as searching for this thing called mental hygiene and then might say, "What is it we are searching for?"

I have come to this meeting with anticipation because I hope that here I may find the answer to the question. I am certain that many other ordinary persons and I will never find out what we mean by mental hygiene from these tremendously thick books that are piled up on our desks. We take them up, but most of us bog down after about 25 pages and never get further. The more I read about it and the more I hear people talk about it, the more I am confused as to what we really mean by a program for mental hygiene. Sometimes I get the suggestion that mental hygiene consists of an assortment of mental pills that come in a variety of bottles labeled with a variety of names. There is a new label every year. I have heard these words so many times that I have found myself using them, not being very certain about what I meant when I spoke them. I reached the stage one year where I told my secretary that if one particular so-called psychiatric social worker appeared again and said to me, "It is a marvelous case of identification," I feared she would not be identified for some time to come. Sometimes it seems that these labels are part and parcel of a very large language that would bother a rural man a great deal more than it would help.

There was a young person in my office one morning who was very able and exceedingly attractive. She was presenting to us a case situation. She said, "This client is having difficulty in the health area." The farmer-physician and I sitting by were as much in the dark as ever after this remark, and so I replied with the question, "What do you mean? Has she the itch, or what?" Language ought to be used to convey meaning.

At other times mental hygiene practically seems to consist of trying to break the patients out in a sort of mental smallpox, and by such breaking out it seems to be supposed that they will be immune from all sorts of mental difficulty ever after. I believe this is sometimes called "analysis." Sometimes hygiene seems to be mixed up with sanitation, but I suppose there are times when a mental bath is helpful. I have sat through some so-called clinics after which I was glad of an opportunity to go outdoors and get a breath of fresh air or to get a copy of Sidney Lanier and take a mental bath myself. This is the picture of how the meaning of mental hygiene is apt to be confused in the mind of the average man.

There is one thing certain, and that is that those of us who were fortunate enough to be at the dinner at the Willard Hotel last evening got a good course in mental hygiene from our good friend, Dr. Plant. There is another thing about which I am certain, and that is that the average country boy knows that basically there is a need for the kind of service we visualize. There are very definite mental hazards that a boy in the country feels just as though he lived in any other part of the world, and as I hear psychiatrists in the city describe certain emotional difficulties they are recognizable to me as something that I as a country boy faced.

I went to school in a sod schoolhouse—something that many of you have never seen. It was very inadequate, and the books and the teacher were inadequate. By accident I came upon a book that told of beautiful schools in another part of the world. In that sod schoolhouse I was as resentful as anyone could be about the inadequacy of my opportunity, and doubtless there are things in my personality now that are the direct result of that experience.

I like the title Miss Atkinson has given us for this meeting this morning, "Mental-Hygiene Problems and Services in Rural Communities." We are facing these problems and not starting out with the assumption that we have the program all set up and ready to carry out. I was glad to see that we had not been brought here to discuss the application of dynamic therapy, or of deep-level therapy, or of some other psychoanalytic technique to farmer boys and girls, even though their needs may be very deep-seated. I doubt whether we are ready for any such finesse in our wide-open spaces. Facing these rural problems thoughtfully until we understand them may lead us to provide the sort of service that will give rural children more than meat and drink, for they, too, "shall not live by bread alone."

We are to hear first something about a method of providing psychiatric services, and I am very happy to present Dr. Howard B. Mettel, chief of the Bureau of Maternal and Child Health, Indiana State Board of Health.

Method of Providing Psychiatric Services

By Howard B. Mettel, M. D., *Chief, Bureau of Maternal and Child Health, Indiana State Board of Health*

Mr. Jones has broken the ice for me because I likewise am not a psychiatrist. I am a pediatrician in search of mental hygiene, as Dr. Crothers' book has set it up. However, my father taught me a long time ago that if you did not know something about something and did not have time to dig it out for yourself, perhaps you could organize a group about you that could teach you something. That is the purpose of my paper this morning—not to take up any methods of treatment or diagnosis of the problems of mental hygiene but to show that Indiana is as primitive as some of our other States in its backwardness in establishing mental-hygiene services, and how we are struggling and beginning to provide a mental-hygiene service, a psychiatric service for children in rural communities in Indiana.

The trend of child psychiatry today is toward the integration of the biologic and social sciences. It includes not only the art of the care of the abnormal child but also the important field of prevention. The needs for setting up a mental-hygiene program for the children of Indiana were evident, but financial resources for promoting an adequate program were not available from any one public-health or welfare agency in the State.

The primary objectives in setting up such a program by the department of health were—

1. To further the activities of the Bureau of Maternal and Child Health of the Indiana State Board of Health in carrying out a preventive public-health program.
2. To cooperate with the State Department of Public Instruction and the Indiana State Department of Public Welfare by giving assistance to schools, and to dependent children who need psychiatric consultation services.
3. To provide better psychiatric training to undergraduate and graduate physicians, educators, and welfare workers, and to teach the importance of the basic psychiatric approach to some of the behavior problems that appear early in childhood but are not often recognized and dealt with until later years.

In August 1937 a mental-hygiene program for children was inaugurated in Indiana. This demonstration was made possible by the approval of the Children's Bureau of the United States Department of Labor. The program in Indiana is under the joint auspices of the Bureau of Maternal and Child Health of the Indiana State Board of Health, and the Children's Division of the State Department of Public Welfare. These two organizations have pooled their facilities to establish and foster a well-organized child-guidance service. It is to be noted here that the annual budget of either of these two

State departments singly did not provide sufficient financial assistance for such a demonstration, and that only by pooling available funds from both agencies was it possible to administer such a program. Since both of these groups were engaged in giving community service in their own particular fields, it was felt that in a mental-health program lay the opportunity for a liaison which would allow for a more unified program. In this manner the services given by each of these groups might contribute more completely to a well-rounded community service and their functions dove-tail efficiently and harmoniously.

The ground work for the child-guidance service was laid substantially by the director of the bureau of maternal and child health and the director of the children's division of the State welfare department. The former interested and obtained the approval of the Indiana State Medical Association, so that medical cooperation became a forceful part of the mental-hygiene program for children. This official approval was also followed by more direct contact with the local medical societies in those areas where the program was to be established first. This type of medical cooperation is always essential in setting up any program which involves medical care or consultation. Other facilities were enlisted by way of uniting more closely the various parts of community service. These included the official State public-health-nursing program, the county public-health nurses of the demonstration areas, and the State department of public instruction, including local school superintendents and principals in the selected areas.

The director of the children's division of the State welfare department and the supervisor of the child-welfare services of the State met with the officials of the specified departments of county welfare and with the directors of the local boards to arrange for a child-welfare worker in each of the several chosen counties. The purpose of these conferences was to outline methods of local functioning and to define the duties of the local worker in each area. As a result the local welfare worker functions closely with the county welfare department, is a member of the official county welfare staff, and works closely with the schools and with various other public and private agencies that deal with the welfare of the children. The welfare worker is an integral member of the community and is in close touch with all aspects of a well-rounded child-welfare program. The director of the children's welfare services assumes the responsibility for the supervision of these child-welfare workers.

It is around the activities of the child-welfare worker that the child-psychiatric services are based, because the child-welfare worker remains the local representative of the service and carries out therapy as planned by the psychiatric personnel. The psychiatric staff is composed of a team that includes a psychiatrist (director), psychologists, and psychiatric social workers.

In order to carry out this program it was necessary to obtain the services of a psychiatrist to act as director of this division. In making this selection a physician was chosen who had had training and experience in child and adult psychiatry and mental-hygiene problems. This provided an adequate foundation for the study of the mental problems of children as evidenced by their behavior. In order to evaluate human behavior properly a psychiatrist dealing with children must be a person who is a medical graduate. This demands an understanding of the individual as regards his physical status, his intellectual endowment, and his emotional make-up. Study of the intellectual endowments and special abilities and disabilities of the patient is a particular contribution of the psychologist. Study of the environmental factors is the offering of the social worker. With these at hand the psychiatrist draws together all available data, including physical status, his own study of the individual and family, and then evaluates, diagnoses, and advises or treats on the basis of the instructive data with which he has to work.

At the beginning of the child-mental-health program in Indiana, with only a single unit of the psychiatric team available, the areas in which the unit could function necessarily had to be limited if satisfactory work was to be performed. Three counties in the State were chosen for the child-psychiatry demonstration. These counties were selected on the basis of the generalized health program already established and the need for such additional services to help round out the health and welfare services. This established program included a child-welfare worker, county public-health nurses, and other cooperating persons, such as the local medical group and the school authorities. Sullivan, Morgan, and Jay Counties were then chosen to receive the psychiatric and psychologic services. The Indiana home for soldiers' and sailors' orphans also receives this service, because the administrators felt a special need for it and because there is already a social-service and medical program established in that institution.

The need for a program of child psychiatry in Indiana is shown by the fact that, with the exception of Fort Wayne, South Bend, and Indianapolis, there have been no places for referring or examining these types of cases in Indiana. In most of these cities this type of work is conducted as a part of the school or educational program and is often conducted by nonmedically trained persons.

There existed no provision in the curriculum of the Indiana University School of Medicine for teaching students the problems of child psychiatry. Therefore this most important branch of pediatrics is little understood or practiced by the majority of the medical profession of the State of Indiana.

In the children's clinic of the Riley Hospital for Children there existed no medically trained person who was qualified to deal with the problems of child psychiatry. Thus far no funds have been available for the establishment of a department of child psychiatry.

Throughout the State of Indiana the Indiana State Welfare Department has under its care a number of dependent and homeless children. Many of these children present mental-hygiene problems for which the State Welfare Department is unable to have diagnosis made and treatment outlined. This problem has especially presented itself to the State Welfare Department in dealing with the placement of dependent and homeless children who heretofore have been housed in orphanages and like institutions.

With the exception of those in the larger cities mentioned before, teachers have no access to guidance in problems of child mental hygiene.

The psychiatric services were actually started in these demonstration areas in September 1937. Preliminary meetings were held with the boards and the children's committees of the local county welfare department. The director of the children's division of the State welfare department, the supervisor, the psychiatrist, and the psychologist, along with the child-welfare worker, attended all of these conferences. Shortly after the services were started the director of the bureau of maternal and child health and the psychiatrist met with the county medical societies, where the program was described, discussed, and approved. Rules and regulations in regard to the eligibility and admission of children to these services were drawn up and approved. Among these was the regulation that each child before being admitted to the service must have a routine physical examination, including a Wassermann test and a urine test. For this routine examination the referring physician or clinic was required to fill out a physical-examination form supplied by the State welfare department, and the referring physician was reimbursed by the county welfare department when the patient was unable to pay. For his private patients he made his own charges. All psychiatric services are free, regardless of the financial status of the child's parents, family, or guardian.

After the medical, social, and psychiatric work is completed, the psychiatrist confers with the referring physician who carries out the recommended medical program if any further medical treatment or observation in the hospital is indicated.

Conferences concerning the program are also held with the school principals as well as with individual teachers. All members of the staff participate in these conferences at various times.

Psychiatric services to the State home for soldiers' and sailors' orphans were started in October. After preliminary conferences with the governing boards and administrative officers of these institutions, the services began. The children were given psychological examinations in order to obtain a broader knowledge of school adjustment or vocational guidance. The greatest number of children referred to the service are those needing school adjustment and those having emotional difficulties. Another important group referred were those who were planning to leave the institutions shortly and who wanted to discuss plans for their vocations, living arrangements, home placement, or to proceed to advanced schools of education. Special services have also been given to orphanages which have asked for help in the understanding of some of their children, and to certain individuals in other counties where acute situations have arisen and where the worker or teacher felt that psychiatric and psychological examination would help in more adequate handling of the given case.

The psychiatrist spends 2 days of each week at the Riley Hospital for Children, which is a part of the Indiana University Medical Center and School of Medicine. Here psychological service is given by the psychology department, which is under the direction of the department of psychology of Indiana University. Although no specially trained children's psychiatric social worker is available at the moment, expansion in this direction is a definitely indicated need. In this area the psychiatrist gives lectures to senior medical students on the pediatric service; makes ward rounds with the intern and resident staff; is consultant for ward cases; and conducts an out-patient clinic for return patients and for those who have not been in-patients but who have been referred from the out-patient pediatric clinic after physical examination has been made. Many children and their parents have been seen by the psychiatrist; some have had a series of subsequent interviews. Recommendations and contacts are made with referring and interested persons or agencies, the parents, the county departments, the juvenile courts, the family physician, or the schools, as indicated.

In addition to actual clinical service rendered by a child-guidance unit, perhaps especially when the service is new, there is the important function of proper interpretation—giving communities and socially minded groups correct information and stimulating local interest. This function leads not only to more substantial backing for the already existing unit but it is hoped that it will create an interest and demand for further expansion of child-welfare services. To this end the psychiatrist has given lectures throughout the State before these socially minded groups, which include State welfare conferences, parent-teacher-association conferences, federated women's clubs, and similar organizations.

It is hoped that the demonstration will stimulate interest throughout the State for an extension of needed services, and that local feelings and interests will be so developed and stimulated that the community or county will ultimately take over the financial and administrative responsibility for the establishment of its own psychiatric unit.

The CHAIRMAN. In line with the general theme of this whole conference, that is, looking at the content of our undertakings, we are now to hear more about the content of a mental-hygiene program, and we are certainly fortunate in having with us Dr. George H. Preston, commissioner of mental hygiene of the Maryland State Board of Mental Hygiene, who will address us on that subject.

Content of a Mental-Hygiene Program

By George H. Preston, M. D., *Commissioner of Mental Hygiene, Maryland State Board of Mental Hygiene*

I was asked to talk about the "content of a mental-hygiene program." I am going to start by saying that I don't believe there should be a mental-hygiene program. Mental hygiene to be effective must be content of a general welfare program and not a program by itself. It is like a religion. You can have a beautiful church and a good minister and you can even have services two or three times on Sunday and once during the week, but if what is preached is not part of the community content, then it is nothing but a nice ornament to show visitors. It does not accomplish anything so far as the community is concerned. I feel very much that way about mental hygiene. If it is a program, it is not anything; but if it is content of a child-welfare program, then it probably will mean something concrete to a community.

I believe I can talk from that basis about the content of a mental-hygiene program, and in deference to our chairman I am going to try to be specific. He said something about the generalities of mental hygiene, and I am going to begin backwards by talking about what the mental-hygiene content of a child-welfare program is not. Certainly it is not just picking out the feeble-minded. You see a certain number of mental-hygiene programs that are concerned only with that problem, but that is not mental hygiene. Nor is a mental-hygiene program only the recognition of psychotic parents, difficult as they may be in a case-work job. Again it is not—and I am very particular about this—the establishment of a special dump for all difficult cases. There is a tendency in the direction of setting up psychiatric service, mental-hygiene service, and then taking everything that nobody else can handle and dumping it on the psychiatric service and expecting miracles. The failure to work miracles serves to segregate mental hygiene and to keep mental hygiene from becoming content of the general program.

Furthermore, psychiatric service is not vocabulary, although it occasionally tends to be. These are some of the things that mental-hygiene programs are not. They are all essentials and I do not mean at all to belittle them.

To my mind those things are like the dishes and the forks and the garbage can in the kitchen. They are essentials to meals, but by themselves they do not constitute a diet. You need to have them to feed people; you have got to have certain services to do a mental-hygiene job, but they are not the job any more than the garbage can is the dinner table. They are essential pieces of machinery but the really important factor lies outside of the tools.

What is important is that the use of any mental-hygiene equipment within a community depends entirely upon the attitude of everybody working in the program. Unless there is a common point of view in regard to mental hygiene that is part of the common equipment of everybody working, these tools are not enough. I am not at all convinced of the value of a few psychiatric specialists working at a specialty within a case-working organization. The value of a specialized psychiatric group within an agency is doubtful because every social-work situation has its mental-hygiene implications.

I read a very interesting article not so very long ago by Professor Jansen, of Duke University, which is in the January 1937 number of Mental Hygiene, and I think it is entitled "The Place of Mental Hygiene in Social Work." It is thoroughly well done. Doctor Jansen brings out the point that in every situation in which you meet social-work problems you find a mental-hygiene layer somewhere, and he quotes one case that struck me as very pertinent. He talks about a professional man and his wife and daughter who reached the stage at which this man could not keep himself going by the fees he was collecting from his clients or patients and landed in a relief situation, with a daughter who was an honor student in high school and with the immediate questions being presented: Do we put this family on relief and try to carry it through? Do we take the girl out of high school and help her get a job to keep the family going? Do we allow the man to continue doing what he can professionally and find a job for his wife? Aside from whether you could find jobs for these people you had at once the psychiatric questions: Are you going to damage this girl's self-respect more by pulling her out of high school or more by putting her mother to work to support her in high school? What are you going to do to this man if you make it obvious to the community that he cannot support himself and that his wife has to go to work for him to keep things going?

It seems to me that questions of that sort, which are very simple, common to all of you, have to be decided on the basis of a knowledge of the attitude and the feelings of the people involved. You must know what this man thinks and feels, you must know what his wife thinks and feels, and you must know what the daughter thinks and feels, and no solving of such situations by rule is going to work.

There are family attitudes and children's attitudes which must be considered before you make a decision as to which one of the various facilities a community offers may be used. The same factors apply to all the problems that arise in a community, for example to the simple problem of telling a family that somebody has tuberculosis. That requires an understanding of people, and in one particular case I know of I think the way in which the situation was explained made the difference between a man who would have gone to a hospital and literally fretted himself to death and a man who could go to a hospital with some assurance and some ability to rest and get well. The difference in the technique was the simple kind of mental hygiene I am talking about.

If that is going to be done, then this thing that we are talking about as mental hygiene must be the common knowledge of all the people dealing with people. That does not mean just social workers.

It certainly means physicians. It means ministers and lawyers and everybody in the community if it is to be effective, but primarily it means the social-worker group at the present moment. There is a beautiful outline of institutional mental-hygiene content in an article by Sybil Foster in the January 1938 Mental Hygiene. It is beautifully done, worth anybody's looking at, whether he is doing institutional work or not, because you can take it right out of the institution and use it in any dealings with children.

I still have not been specific. I have talked about what things were not. The first concrete item in this common knowledge of mental hygiene is some understanding of what human behavior actually means when you see it going on in front of you. At the risk of being very elementary in my talking, I am going to talk about two or three situations.

I remember a small boy of 6 who was being brought into my office. I happened to see him walk down the street outside my windows and stop and pick up a cigarette butt off the sidewalk and light it and walk the rest of the block smoking the cigarette. That was a perfectly beautiful label, "I want to be grown up and I am not having a chance." And you did not need a lot more than that. By the time the boy got in you knew what you were dealing with.

A similar sort of case was that of a boy who came to me and said, "Dr. Preston, did you ever see a hippopotamus?" I said that I had. He said, "Well, you know I saw one out in the lot in back of the house the other day and I did not do a thing but go up and twist his tail off." You do not want people to give you much more than that kind of story, do you? They have just hung out signs for you.

I knew two boys who were about 15, and on the same Sunday one of them slipped away from home and joined the Presbyterian church and the other one slipped away from home and broke into a grocery store. They had exactly the same motivation—no difference in the type of behavior from my point of view at all. Both of them wanted to show the world they had grown up. What they did depended upon the pattern of the home in which they had grown up.

Those are the simple sorts of things that mean mental-hygiene content. Somebody said once that there was a group of social workers still in existence that believed it was not worth while to listen to a story of distress unless you could do something about it. That just does not make sense from the mental-hygiene point of view, because, of course, the actual telling of a story of distress to somebody who will be decent enough to listen is good therapy. Patience, tact, and frankness and not throwing the person out of the office is good psychiatric therapy by itself—good mental hygiene in the sense about which I am talking.

Understanding of the meaning of human behavior is one of the essential mental-hygiene components. The second is much more difficult to attain. It is the need for every worker in the children's field or in the social-work field to be able to face without prejudices any type of behavior that happens to be presented. The doctor is in exactly that situation. If he approaches a patient with the feeling that the patient or the patient's condition is nasty or dirty, he cannot treat the patient. The social worker who approaches a situation and says, "I can't stand liars," or says, "I can put up with anybody except a client who is cheating on me," is not mental-hygiene conscious. That is personal prejudice. That is emotional astigmatism. And it is one of the things that give you an improper point of view in dealing with people.

You cannot approach a client as a drunken bum and do social work with him. And unless you can approach him with a question, "Why is this man doing the kind of thing he is?" you cannot do social work with him. You cannot walk into a woman's house and discover that the beds have not been made for a week and the dishes have not been washed since last Sunday, and approach her as a filthy, dirty, low-down housekeeper. You have got to approach that sort of thing with the feeling, "What is this all about—why is this person doing the kind of thing that she is doing?" There is the need for not letting personal prejudices get in the way of your social-work technique.

You may say that these things are ordinary common sense. I grant that they are for a few people who have had a great deal of experience, who have met many people in many places, and who are themselves relatively well mentally. These things are matters of character that you may acquire in the course of 70 years of living. They are also things that can be acquired by technical training. It is possible to acquire an understanding of what human behavior means, and it is also possible to compensate for personal prejudices by careful technical training.

The essential content of a welfare program is mental hygiene, and by that content I mean that every worker should know what the human behavior that she sees means. She should be able to face any type of human behavior, recognizing her own prejudices, and making allowance for them so that it can be approached unemotionally with the question, "What is this person doing—what does this thing mean?" rather than saying, "This is something I cannot stand."

With that sort of content a program ought to develop in two directions. First, it should be developed so that the work can be carried on without too much damage to the client. I say "too much" advisedly. I believe it is a rare individual that handles a social-work case or a medical case without doing some damage to the personality of the client.

I am going to mention just one phase of that because I think it is the most important thing we are facing in this country at the present moment. The mental-hygiene content of a welfare program should be such that it would be possible to handle clients on relief without damaging their self-respect. That is the only hope that we have of not producing a few million chronic dependents and professional beggars, and that is the responsibility that rests upon the mental-hygiene training of a social-work group. If you put a person on relief in a way that destroys his self-respect, that person is not coming back. I believe the mental-hygiene content should be developed in the direction of protecting the client from damage, particularly in relation to his self-respect.

The other direction in which this content should be developed is to make it possible for the worker to foresee trouble before she gets into it up to her neck. A knowledge of the attitude of people and what things mean to them will make it possible for her to see that certain things cannot be done with certain people, that other things can be done, and will prevent her from getting into a situation in which she and the client are both helpless and which neither has stability enough to retreat from. You see it takes a lot of stability to admit you are wrong and to walk out of a situation and start over again, and it takes a lot for the client to admit that he has made a mistake, so that pushing him into a place where he has got to admit he is a fool is just a mistake. A mental-hygiene content ought to make it helpful to foresee danger before you land in the middle of it.

When we begin to talk about the way this sort of content ought to be developed in a program, let us assume that we have the base of a child-welfare program in a community and that the training of the people doing the job is average, so that the ordinary technique of child-welfare work is done automatically. The first requirement in developing a concrete mental-hygiene content in a child-welfare program is please get healthy workers. That is a very difficult job, but essential. I mean by that people who do not have too many prejudices. They are people who are not too narrow-minded, people who are not too personally peculiar, and people who are able to change. One of the characteristics of mentally ill persons is rigidity. They develop one method of meeting difficulties and they go right along with that method regardless of the difficulty. We talk about dead people as "stiffs," and you do not want that kind of person on a social-work staff. They are of no use. You want people who are flexible and who are not too sick mentally. The next step is to have a supervisor or somebody, whatever you call them in the organization, who knows mental hygiene. That person should not carry cases, because the minute she begins to carry cases everything difficult in the organization gets dumped on her. That person needs to be a consultant, a person who can be approached, who should approach everybody doing a case-work job that involves problems, and who can teach mental-hygiene attitudes to workers.

And one more thing. That person should have an opportunity to carry mental-hygiene content to every other agency that deals with children in the community—the juvenile court, ministers, doctors, school teachers. If mental hygiene does not exist widespread through your community it does not do any particular good. If you build up a nice mental-hygiene job with a child in a family and put him in a school that does not know what you are talking about you may have the whole thing undone, very promptly, by something like the following: I walked into a classroom on one occasion and the teacher said, "Oh, children, here is Dr. Preston, you know what Dr. Preston does, he takes care of all the foolish children. Johnny, I wish you would come up here and let Dr. Preston look at you. He has such a funny head, Doctor." I think that is the story. This thing is a matter not of program but of content of existing programs. It is like the salt in the soup. The salt by itself is of no use, but without the salt the soup is not fit to eat, and that is my point of view in regard to the content of a mental-hygiene program.

The CHAIRMAN. Our next scheduled speaker, Mrs. Robbie Patterson, supervisor of child-welfare services in Nebraska, is unable to be present today, but we have her paper and it will be read by Mr. Harry Becker, director of the Child-Welfare Division in the Nebraska State Board of Control.

Contribution of the Social Worker to a Mental-Hygiene Program

By Mrs. Robbie Patterson, *Supervisor, Child-Welfare Services, Child-Welfare Division, Nebraska State Board of Control*

In a mental-hygiene program we think of the psychiatrist, the psychologist, and the social worker, because each has an essential and specialized contribution to make.

In considering the place of the social worker in a mental-hygiene program, we are presupposing that the worker has at her command an adequate working knowledge of and a belief in mental hygiene—a knowledge that understands human relationships and human reactions to environment. The social worker is a person who has acquired distinctive knowledge and experience and has added definite personality developments to this knowledge and experience. Social workers in mental-hygiene programs should be persons who have reached maturity and have found in their own achievement a basis of security with respect to themselves and to their professional obligations. They should be free from prejudices and preconceptions, realizing that prejudices and preconceived ideas are likely to dominate the handling of situations. On the other hand, social workers should be able to let reasoned conviction based upon a study of facts take the place of dogma in regard to human behavior. Workers also must realize the danger of an exaggerated sense of authority on their part in assisting clients to develop a capacity to make their own adjustments of life.

The social worker in a mental-hygiene program is in a strategic position to do an important piece of educational work in the community. Through her relationship with the psychiatrist, the worker's knowledge is increased, and she is able to interpret to the community what the functions of a mental-hygiene program are. Social agencies are subject to the demands made upon them by the communities. As the social worker in the agency deals with the problems involved in the demands, we become increasingly aware of new aspects of the problems, of the need for new understanding on the part of the general public or the strategic groups within the community, and frequently the need for the development of new forms of effort in order to meet adequately the problems of the socially maladjusted individual. The social worker is invaluable in her personal contacts with the doctor, the teacher, and the judge, in bringing about a better understanding of problems involved in the treatment of dependency, delinquency, and other social maladjustments.

In an educational program it is important that social workers keep in mind that mental hygiene is primarily concerned with the normal and not the abnormal. They then make a positive rather than a negative approach. We should remember that the positive educational aspects of mental hygiene are relatively simple, understandable, and susceptible of being developed into principles of living.

A great deal that mental hygiene has to offer in a positive educational way does not call for mental-hygiene clinics. It is recognized that if the principles of mental hygiene are to be applied on a sufficiently extensive scale to be effective upon the mental habits of people generally, these principles, for the most part, will have to be applied by persons who are not specialists or experts. Such principles are applied by the social worker not with the familiarity of the intricacies of psychiatry, but with an understanding of the simpler but highly significant fundamentals of positive mental hygiene, which is reflected and practiced in the contacts with others. The position in the community and the relationship with the public afford opportunity for interpreting the services of the psychiatrist and advising expert services where needed.

One of the social worker's greatest contributions to mental hygiene is aid in removing many of the ancient superstitutions and prejudices that, in the past, surrounded mental illness. The social worker has played a great part in the concerted effort to bring about a realization that mental diseases, like physical diseases, are subject to cure and improvement, as well as prevention. With the psychologist and psychiatrist, the social worker is aiding the public to see that there should be no hesitation about seeking early and expert treatment for mental illness.

The social worker has to assume a large responsibility in guiding the educative process to meet the needs of the individual. Whether these educative experiences are of a social, intellectual, physical, or emotional nature, or a combination of all four, it is necessary that the interpretation of the growth process be related to the limitations and capacities of the defectives and the subnormal as well as the superior intellectual group.

The social worker in the community frequently finds herself in contact with the beginning and occasionally with well-developed problems of mental disease and deficiency. Early recognition of the possibilities of training, with emphasis on the specific needs of the defective child, makes it possible to promote better-organized educational and social opportunities for these groups.

Because of her position, the social worker has an opportunity to bring to the attention of the psychiatrist many individuals who need care in the early stages of mental break-down before deterioration begins. This may increase commitments, but it makes for better prognosis. As the social worker is an important factor in the early treatment of mental diseases, so she is an important factor in the preventive aspects of mental hygiene, some of which are the direction and guidance of parents in the handling of their children and making contacts with school authorities, through which helpful guidance may be given in meeting the needs of individual children

This leads us to think of the social worker in relation to the schools. Children, as the result of physical disability or deep emotional disturbance or for some other reason, often cannot conform to school standards. A competent case worker brings her skills to the aid of the teachers and parents, often building a guidance program in the school, but more often giving a better understanding of the child.

The social worker makes a contribution by providing leadership in relationship to the client and to the community. In discussing the leadership of the social worker in their book, Mental Hygiene and Social Work, Lee and Kenworthy point out that the relationship with the client is the keystone to successful treatment. To this relationship the worker brings the combination of working knowledge, point of view, and adjusted personality, added to the ability to handle oneself in such a relationship so as to make social case work an art. It is this relationship that enables one to conduct oneself in all contacts with the client so as to enable him willingly to accept the suggestions which the worker's knowledge of mental hygiene and social work enables her to make. When a mental-hygiene program is new, the social worker is the leader in interpreting the services of the psychiatrist to the client. It is she who can help a mother understand that because she has talked over the behavior of her 12-year-old son with the psychiatrist she will not be regarded as "queer," or because the son makes weekly visits to the psychiatrist's office he is not mentally deficient and ready to be committed to an institution. The social worker also must assume responsibility for explaining that a "magic spell" will not be worked in a day by the psychiatrist and the child or his parents be made anew.

As a leader in the community, the social worker is called upon to develop attitudes that will lead to the acceptance of mental hygiene. In a rural community there is so much neighborliness that what the worker does is more or less shared by the whole group. Everyone knows that the Joneses are finding it hard to understand their adolescent daughter, that the Browns are receiving relief, that the Smiths' daughter has a child born out of wedlock. This responsibility of interpretation may seem anything but an asset, but there are definite values in this function. There is an opportunity, in talking with the lay public, to develop a better understanding of the responsibilities to the unmarried mother or to interpret the needs of the child rather than of the adults in the foster family in the placement of dependent children.

The worker in the community, then, has an important function in the modification of the attitudes of parents, teachers, judges, and lay groups toward people whose self-expression may conflict with the generally accepted practices of the community. It often becomes difficult to maintain a nonjudgmental attitude, but this is necessary if the worker is to become an integral part of the community and be its leader in developing harmonious community life.

The social worker should share in the successes of the progress of the mental-hygiene program. A good many of the cases come to her attention first, and she is responsible for collecting the social data and social study. She is keeping ever before her the control of client-worker relationship so that the client will reveal how the history functions in the present situation in determining the attitudes and in conditioning the reaction. The worker further will be objective and attain the social workers' goal of social adjustment without invading the psychiatric field of dealing directly with the personality difficulties. The worker brings to her aid general interest, penetrating understanding, sincere good will, quick responsiveness to the client's groping efforts. In advising psychiatric care, she evaluates the social data, keeping in mind the treatableness, the limitation of the situation, such as time element, funds for boarding care, and accessibility to the psychiatrist. It is the social worker who is always in constant touch with the reality and practicality of the situation.

We are finding a change in public attitude all over the country. Social workers are being accepted in counties and areas untouched before. The recognition by local public officials of the need for casework services is hopeful. Public officials are coming to see that the lack of economic security, poor housing, inadequate health, and poor educational facilities are social ills. Situations presenting a wide range of problems are being referred to the social worker by the county official, the layman, the neighbor, the client himself. Many of these situations, ignored before, are now being faced, and we find county boards willing to pay for medical services and for boarding care. Also, we find lay persons serving on advisory committees, organizing clinics, and volunteering their services in community efforts to solve environmental problems affecting the well-being of the individual.

DISCUSSION

The Chairman. We are now to have some discussion of these matters. Those who have been selected for discussion will be given first opportunity. First I shall call upon Mr. C. F. Ramsay, superintendent of the Michigan Children's Institute of the State Welfare Department. I understand that the discussants may discuss matter in any of the papers, so you have a free hand, Mr. Ramsay.

Mr. Ramsay. I do not think I should have the audacity to presume that I could properly discuss the papers that have been presented. I happen to be just a social worker on the firing line who sees some children that are sent to us and for whom we have to make some future plans. We did not have the privilege of knowing what the papers were going to contain today, and therefore could not prepare in advance a discussion of them. I was probably chosen to bring to you the experiences we have had in Michigan in this work. I think that we can agree with Dr. Preston, of course, that mental hygiene is just one part and should be integrated with the entire program.

There are some fundamental truths that it seems to me are very common to mental-hygiene programs and as social workers we are not fully cognizant of them. One of these truths is the fact that change in social conditions among mankind is a very slow and arduous process and that very little effect comes from external forces. That is, most of it has to come from inside the individuals themselves, and any kind of mental-hygiene program must accept this slow process of inner forces acting on the individuals who are responsible for any program that pertains to the welfare of children. In order to alleviate distress it is fundamental that social workers should approach the problem with sympathy and good will but without the attitude of coddling or coercion. The social worker may also find himself in between pressures of the community that asks that something be done with a family or with children and the rights of individuals to resist that contact of society with their prejudices and with their resistance to change.

In our experience in Michigan I cannot help but think we have had the beginning of some chance to change these attitudes and prejudices on the part of the community with our child-welfare services. We have not placed in each rural community a full-time child-welfare worker but have exposed the community to some of the newer processes and techniques of social case work, and as we have gone from county to county we have appealed to the probate judge, because he decides what happens to children that are brought to the attention of public authorities. He has the power under the law to take them away from their parents, to assign them to institutions or agencies or to commit them to suitable institutions, and he is the key person as far as the public child-welfare program in the counties is concerned. Through our child-welfare services we have brought to him the supervisor who discusses the problems of the families of children that come to his attention and offers the services of trained social workers and psychologists to advise with him. When the social worker and the psychologist have gathered all social material and completed the mental examination of the child to see what the potentialities are, a conference is called of the representatives of all the interested agencies in the county—the health people, the school people, and the relief administrator, the county welfare agents, and the probate judge. The social worker presents her case on the basis of facts found and without any preconceived ideas of her own. Out of this group conference comes some suggestion of group thinking and "What have we in our county that can help this particular family or help this particular child?"

We cannot help but think that such an approach may bear some fruit in changing the attitude toward the disposition of children that come before the probate judges, because in many instances this is the first time in the county that any of these people have ever got together and talked about the whole child. And we cannot help but feel just a little bit of pride, as it has been only 2 years now since that service has been inaugurated. We feel that we are beginning to get some sign that maybe the result of the investigations by the social worker and the summary the worker has sent back are bearing fruit, because the thing that we are aiming at, which we did not propose at the beginning, is the fact that we would like to have the judges refer problems to the agency before any disposition is made. Under the law we do not have that privilege, but in the county where we first started to work in April 1936 the probate judge is now beginning to write letters saying, "I have a family in which the children have been called to our attention and I would like to know what we are to do about it. Have you someone you can send out to study the situation and see whether there are any suggestions that you can make?" There may be a mother who is going down to the university hospital. "Will you have some worker interview her to see what are the best plans to be made for her child?"

I think that is what Dr. Preston was trying to impress on us—that the changing of the attitude is a slow, long-drawn-out process. But I think the social worker who has the training and the experience and probably not so much the knowledge of what to do as the knowledge of what not to do is needed in inaugurating a mental-hygiene program for children in the rural counties.

I think that he has brought out for us in his remarks that psychiatry is the tool of a social worker; that the social worker should draw on all the resources of health, education, and psychiatry, and everything else that we need to understand problems of children that are presented to us. With all the advancement we have made so far we are still far removed from knowing all the answers to the problems that children present, and if we can integrate these other services I think we have the beginning of a mental-hygiene program. In conclusion, I want to say this: I could not help but be impressed with Commissioner Adie's remarks last evening, and also the remarks of Dr. Plant, indicating that those in administrative positions in the public-welfare departments of the States could start with the individual and work up, thus having some realization of what is being done for the individual that the administrative agency is trying to serve. Those of us in the child-welfare field would welcome the day we could leave out the name of child-welfare service and call it by the broader name of social welfare.

The CHAIRMAN. Now we move from Michigan to Maine, and Miss Lena Parrott, consultant on child-welfare services of the Bureau of Social Welfare, State Department of Health and Welfare, will continue the discussion.

Miss PARROTT. When I noticed that I was on the program I wondered a little, because we feel that while we have made progress in Maine along many lines we have not done very much in mental hygiene. But after I heard Dr. Preston's remarks I began to feel that we have done a little bit of what he thinks is the right thing and a little bit of what he thinks is the wrong thing. So I am glad to tell you what we have done, whether it is right or wrong.

I think the wrong thing we have done is to take down to Boston to the Home for Little Wanderers our most serious problems—the ones we could do nothing with. We sent them down to Mr. Jones and I must say that he, in a good many cases, did a very good piece of work. Sometimes he sent them back and told us that he wished we would not send any more cases like that. So we are beginning to learn to work together a little better and get more service, but we do appreciate what the Home for Little Wanderers has been able to do to help us with special child problems.

In developing the child-welfare program in Maine there seems to be an overwhelming need to set standards for case work, and we put most of our emphasis on providing supervisors who would have general supervision of the workers caring for some 5,000 children who are under the care of the bureau. About 2,500 of them were committed children and 2,500 children receiving aid to dependent children. We were very anxious to find, and we did succeed in finding, supervisors who had had good case-work training and experience, with a generous amount of mental-hygiene training and experience thrown in. And it has been, in the 2 years we have been operating, most gratifying to see the change of attitude toward children and their needs and the place of the child in his own home and his feeling for his parents. In the past I think the State—and if there are any Maine persons here, I will stand corrected—has been very kind to its children. It had a very paternalistic feeling toward children, but that very feeling of protecting the child has in the past led it to do what seem to me to be terrible things to children. The State seemed to feel itself so much more adequate to care for the child than were his parents that children were often uprooted and grew up with no knowledge of their parents. I think workers in the past felt that when a child was removed from his own home a curtain was drawn between that child and his family and that there never was any need for the child to want to peep behind the curtain to see his parents or to know anything about them, since the State was quite capable of filling their role.

So in these 2 years there has been a tremendous change in the attitude toward a child and his own family. There has been a difference in the attitude toward the child and his behavior, of understanding him and his needs, and why he is presenting some of the difficulties that he does present.

So, as I heard Dr. Preston talk, I thought that by the selection of supervisors with that particular experience we really had gone a little bit farther in our mental-hygiene program than I thought we had when I first came down. We have had one institute for the workers. It was held by a psychiatric social worker who was in child-guidance work. We hope that we may have more institutes for the workers, plus the everyday help they get from their supervisors, so that, Mr. Jones, we will not have to send so many children to you.

I think the Children's Bureau would like me to speak about what we have tried to do to use to the best advantage the available bed space in the one school for the feeble-minded in the State. As in most States it was almost impossible to get a child into the State institution for the feeble-minded. It was crowded and no one thought of making the effort to find out whether another child could be placed or where there would be an empty bed. Three years ago a building program was started and a new building for mental defectives was completed. It had a capacity of about 350 beds, and last year when the legislature was making an appropriation for the maintenance of the new building it was staggering to find that institution had 350 beds but a waiting list of about 425. It was an endless job—no sooner was a building finished than there were more people waiting to get in. It was found that the institution had no field service and no one to examine or study applications. It was also found that the waiting list was an accumulation of 6 or 7 years, and it was decided by the budget committee of the legislature that before an appropriation was made the Bureau of Social Welfare, which is the State agency with a field staff, would make a study of these applications to determine what their status was. This proved to be very interesting. Of the first hundred studied only 60 applicants were really in need of institutional care. It was discovered that some had died and some had been committed to other institutions; that in a great many cases the families had found that they could care for the defective persons themselves. In other instances some well-meaning person had led the family to think that if the child was sent to the institution he would have a training and an education which would fit him for life. And when they found that the program might not accomplish that a great many of the applications were withdrawn.

We found also a situation that had made for much misery and unhappiness. It was written in the law that there would be four classifications. First preference was given to a person who was in a State institution or who was being supported from public funds. The next classification included persons who were in public institutions but were being supported partly from private sources. In the third group were persons receiving town relief, and in the remaining group were persons whose families or relatives were able to pay for their care. What we found was that in the third classification particularly, and the fourth, too, were persons who had been struggling with children in their own homes; that we were probably admitting to the institution from the first two classifications children and persons who were not as much a problem either to the community or to the family as the ones in the third and fourth classifications; that families were just being wrecked by the strain of this burden. This led to legislation that abolished the classifications and the order of admission, and the institution took the most urgent cases. Another result was that the Bureau of Social Welfare accepted responsibility for investigating and studying all applications to the institution before applicants were admitted. And the result is now that if a person, because of behavior or the strain on the family, does need institutional care, it is not quite so hopeless to get him in. We are able to get care for our more urgent cases as a result of this study of the problem.

The Chairman. We are now going back to the Middle West and will hear from a psychologist, Miss Evelyn Ehman, of the Illinois State Department of Public Welfare.

Miss Ehman. I think it is interesting, in view of Dr. Preston's remarks about mental-hygiene programs as such, that the Illinois program for child welfare started out with no special provision for mental hygiene. Illinois for many years has had a very good child-guidance clinic in the Institute for Juvenile Research in Chicago. That clinic has mainly served Chicago, but it has developed some traveling-clinic units which serve communities that have been ready for that kind of service.

I do not believe there was much thought, at the time of establishing child-welfare services for the rural areas, of beginning the child-guidance service in those areas immediately; but out of one part of the child-welfare services a program came as a result of the demand for something similar to this mental-hygiene work.

Illinois has made plans for four demonstration areas—that is, counties in which child-welfare service will be undertaken extensively; and in two of these counties the work has been going on for almost a year. In one of the counties it was obvious that there were many children about whom we needed to know a good bit more than we could have learned from what the resident social workers could gather. For instance, it was necessary that we have mental-test data and sometimes the study that a psychiatrist could give, and so it was necessary to develop some sort of service to take care of that. Also, it was obvious that this program was designed from the point of view of preventing these behavior difficulties from occurring. And so in Illinois we have taken the track of providing in these demonstration areas for the individual problems by developing a psychological and psychiatric service, but also by bringing our program directly to the rural schools.

It was possible to proceed to the teachers' meeting in one little village school. The teachers met every week in the afternoon to discuss their problems. They were discussing a book on the mental hygiene of school children, and it was possible for the school counselor to be present during those discussions and to take advantage of whatever opportunity came up for interpretation.

In another school we found the principal worried about the fact that many of his freshmen were poor readers. The grammar school and high school are in one building in that village and we could go back to the elementary grades to the origin of these reading difficulties in the first, second, and third grades. Eventually we can get the school thinking in terms of individual differences and provide for meeting these differences before they become a serious problem.

In the rural schools themselves we had some interesting developments. There was one rural-school teacher with 18 students who was very anxious to hear from the school counselor, and she very readily accepted the suggestion of ordering group tests and achievement tests for all of her children. The point behind that suggestion was that if this teacher could actually see the individual differences of this group it might be possible for her to think in terms of a program for each child. As it happened, she had one child who was seriously mentally defective. She felt that this girl should not be in school, that she should go to an institution. As it happened, the girl was learning as much as she could in that group. The teacher had taught her up to a capacity level and had also made the program as comfortable for her as she could in that schoolroom. The child was giving no special difficulty except that she was different from the other children. It was suggested that it was not so necessary to send this child away just because she was different. It was suggested that this teacher could be working out a relationship with the family that would provide protection for this child in the event that she did become more suggestible. Then this teacher had a very bright child who was in the sixth grade at that time and who measured up to eighth-grade level in ability and achievement. In this little rural school it is not possible to give a great variety of materials and subjects, and it was suggested that the teacher see if the child could complete the seventh and eighth grades in 1 year and let him enter high school a year earlier. She said she did not think that would be a good idea because this youngster might not be able to go to high school very long; that it would be difficult for the family to send him to high school because it would be more expensive. He would have to go out of the community and would have to have bus fare, and so on. The other side of that problem was that this child very probably would have to drop school after he was 16, and that if he could enter high school a year earlier he would get far more from the school program than if he kept the regular pace of a grade a year.

The approach to the rural schools has been optimistic and we cannot talk about any program—in the first place it has not been going very long—but we have in one county created a position defined as school counselor, and the county superintendent of schools has announced to all of his teachers that the service of a school counselor is available.

We have talked to school principals and to school teachers and have visited rural schools before the psychologist was available to this unit. A number of children had been referred whose problem seemed to be mental deficiency, and the case worker in the unit had arranged for group mental tests to be given by a nearby college. Well, these children had been gathered up from various ends of the county and had been brought in as one group and had been given a group test, and the material that was obtained from that test was not felt to be reliable. It was felt that it was not safe to give it out in too impersonal a manner, so we made a point of visiting teachers and discussing child problems with them. As a result of that discussion we heard of other children through the teacher's saying, "Well, this child isn't known to the child-welfare service, but I wish you could tell us about him," or "I wish you would see what you can find out about him." Of those children who were supposedly mentally defective we found one to be a perfectly normal child, but he had a reading disability and we were able to demonstrate to his teacher the use of reading diagnostic tests and also to give suggestions for remedial treatment.

It is along that line that we are hoping to develop the understanding and the thinking of teachers, and I suppose there are two lines of attack we are pursuing. I think we are encouraging the use of mental tests and achievement tests for what they can show about individual differences in children and, of course, in the mechanism and behavior and understanding of children's problems. These might be worked out through the child-welfare-services staff or through the teachers' colleges in the State. Thus far the teachers' colleges have not given much leadership, and their bulletins do not show many courses built around that particular problem.

So far as the eventual placement of this service is concerned, perhaps it should be tied up with the department of public instruction: perhaps it should be in the county superintendent's office. But for the present we are hoping to bring as close to the teachers as possible this awareness of what is behind many of the problems and the behavior of the children that they have in their classrooms.

The CHAIRMAN. I regret that we must adjourn earlier today on account of the afternoon program. I wish we had another hour for further discussion.

The conclusion of the matter, as I got it this morning, is that we are realizing that children, like adults, are persons, and that they live in a world of emotions; and we who call ourselves child-welfare workers had better think not so much of doing things for or to these children as of doing things in company with them. What we are talking about is not only the content of a program but the content of life. We are trying, of course, to find social machinery that will facilitate our understanding of the business of living with our children. We have had suggested the possibilities of traveling clinics with specialized facilities, which certainly are being found useful resources in many places. There is also the suggestion of a somewhat centrally located house "by the side of the road" where children who are not quite "roadworthy" at the moment may go for a while and be studied by people who are especially qualified to make such exploration. None of these facilities are real things of real value except as they are enlarged and enriched and quickened by our genuine understanding of the personality of the child. From Dr. Preston I gather that the thing that will matter most will be what these undertakings do to our thinking and our attitudes.

We realize at this moment that there are points that we have not touched this morning and that we would like to discuss. The whole question of parent and teacher relationship is one in which I have become much interested and about which child-welfare workers may do more thinking. It would be easy this morning to launch a discussion of the subject of adoption, in which field there are great hazards for children. From hearing Dr. Plant and Dr. Preston talk I get a deep and what seems to me a very important conviction that life can do something for itself and that very often it can do what it needs to do for itself, and that the hazards of transplanting young life too quickly and thoughtlessly are very great.

Last night I happened to be reading "The Last Empress," the story of a Chinese woman who was a contemporary of Queen Victoria and who kept her hands in the affairs of China for a long time. It is a very interesting and significant story. Here was a little Chinese girl who was not born to royalty but who arrived there because of her beauty, wit, and intelligence, along with her drive for power and the force of circumstance, enabled her to become a real ruler. There is a threatening, even terrifying, yet lovely picture of her childhood after the death of her father. The author, who probably has not thought in terms of child-welfare programs or psychiatric programs, speaking of the early experience of this little girl, said:

> The fact of having acquired some personal knowledge—even at so early an age—of the realities of life as known to her subjects gave to Yehonala in later years a notable advantage over those members of the Imperial family who had been brought up from infancy in the seclusion of the palace.
>
> A child's experience of a modest household, with its little economies and expedients to keep up appearances, would not seem of much use as training for one who was destined to rule over a fourth of the human race. Yet it served as a corrective to that ignorance of the world as it is, which has so often been the ruin of an Oriental despotism. Like her subjects, Yehonala knew nothing of the barbarians who lived beyond the Four Seas. But she knew her own people well.

And so the very circumstances of life from which we would sometimes rescue children may be fitting them for the responsibilities that are to come.

Tuesday, April 5—Afternoon Session

RELATION OF CHILD-WELFARE SERVICES TO FOSTER CARE

Jacob Kepecs, Executive Director of the Jewish Children's Bureau of Chicago and Member of the Advisory Committee on Community Child-Welfare Services, Presiding

Statement of the Problem by the Chairman

This morning I was stimulated by one of the talks on mental hygiene in which content rather than program was emphasized. We were told that child welfare should not be segregated or isolated in a segment separate from other case-work activities.

Child welfare really belongs to social work and should be so considered. I think that child welfare and the child-welfare services serve social work in a very useful way. Miss Julia Lathrop has been quoted as saying that the juvenile court helped to make the child visible. Well, I will say that the child-welfare services make social work more visible. And I should add that foster care has made child welfare more visible. For a long time child welfare was synonymous with foster care; when we talked or thought of child welfare we meant foster care, and very naturally so, because foster care is dramatic. There is not much drama or excitement in looking after a child in his own home. Nobody sees it, nobody knows about it unless you "yank" him out of his home and put him in an institution or foster family. That is dramatic and everybody sits up and takes notice. So let me repeat, child welfare makes social work more visible on account of the natural interest of people in the child. Somebody said yesterday, I believe, that in one of the States you can get anything for any child if he comes from a worthy family. I am inclined to believe that you can make almost any child look "worthy."

Our subject is the relationships of child-welfare service to foster care or the place of foster care in the child-welfare services. It seems to me that foster-care provisions and resources are an essential part of child-welfare services. A complete or comprehensive child-welfare-services program without some provision for foster care is unthinkable The question is how much foster care is needed. Do we need foster care for one child in each thousand or in each 2,000 children in the community? What is the total number of places we need, and how large a program of foster care is required? I do not think that figures are available. A guess is possible, a guess based on experience and some familiarity with the field. My guess is that we need foster-care facilities for a minimum of one child to every thousand children in the community. This is a dogmatic statement, I am aware, and I could not substantiate it if you challenged me. Furthermore, it must be qualified in relation to other services and assistance resources in the community. I am fairly certain that there is something wrong if you have less than one per thousand or more than two per thousand children in foster care.

What kind of foster care do we need? Well, I would say that institutional care alone or institutional facilities alone will not do, nor will free foster-home facilities alone do. We have to have various types of foster-home facilities in order to function fairly adequately. What does it cost? Well, that varies, but certainly we cannot have foster-home care free of charge. Even the selection of free homes and adoption work cost money, and these services are extremely limited in a foster-care program. What kind of skill is required? That is very important, because when you work in rural areas where you cannot possibly have specialists for various phases of case work it is very difficult to say that you must require experience or training in foster-home work before placing children. It would be unreasonable to require that; certain situations demand placement. But it seems to me that it is not unreasonable to require of child-welfare-services workers that they should have had some courses and perhaps some experience in foster care. Workers in child-welfare services should have had some contact with or should have been exposed to foster-care work. But if not all the workers have these qualifications, at least some workers in the child-welfare services should.

Every good case worker knows, of course, that not all families, no matter how good they may be in themselves, are suitable foster families. This is very important to remember. Any good case workers should be able to do foster-care work in urgent situations. It should be done very carefully, and the worker should remember a few simple but fundamental principles, such as are to be found in "ABC of Foster-Family Care for Children," published by the United States Children's Bureau, and in "Reconstructing Behavior in Youth." In the areas in which child-welfare-services demonstrations are carried on it is difficult to find experienced child-placing workers. It is also a problem to get the money necessary for foster care. There are many other problems, as you well know.

There is the problem of the relationship between voluntary and Government agencies in the field of child care. The voluntary agencies, and in particular the old-line institutions, feel themselves threatened by the child-welfare services and by aid to dependent children. They are quite worried, because they do not know what is going to happen to them. They feel that the Government services and assistance provisions are competing with them, and perhaps they are. How is the situation to be met? Unless you can work out some kind of cooperative formula, you will find your program blocked. Those on the defensive fight hard, and the private agencies are on the defensive and are going to fight for their existence. Unless we can find a way or an acceptable formula, the Government program will be hampered if not blocked. The problem is rather complicated by the prevalence of the subsidy or compensation system. I call it a subsidy, because I believe that private agencies, particularly sectarian child-caring agencies, want to do their work. They are not waiting to be asked to do it. They want to do it under any circumstances if they can afford it.

They naturally welcome Government help. It makes it much easier for them to do the job. I call that a subsidy. Others call it compensation, because it is the Government's responsibility that the voluntary agencies carry, and if the Government depends upon the private agencies to discharge its responsibilities it is only right that the Government should pay the cost of care and service. In that sense it is compensation.

Another problem is to get the voluntary agencies to modify their program. Usually the voluntary agencies, particularly the institutions, have a rigid program; and unless they modify their program to make it more flexible, they will be less useful in the scheme of things. The question arises, how can we get the private institutions and agencies to modify their program?

Still another problem: Are you going to insist upon minimum standards? If you are going to compensate or subsidize private agencies, can you insist upon minimum standards of care, including a minimum of case-work service at the point of intake, during care, and at the point of termination? Will you require Government supervision? Local public agencies and institutions require supervision and minimum standards as well. Voluntary agencies under the most favorable conditions are limited, and must remain limited in their services. They never have met the whole job and never will. This we must accept.

Which part of the job then are voluntary agencies to do, and to what extent is the Government to supplement the services without engaging in competition? Competition is not confined to private agencies or private and public agencies. In many parts of the country, including some of the areas in which child-welfare-services demonstrations are carried on, competition exists between Government agencies. In some places you have the juvenile court resisting the child-welfare services. It desires to do the whole job, including foster care. Some juvenile courts feel themselves threatened by child-welfare services and by the other social-security measures. How is that to be met? There are also the county homes for children that are threatened by the newer developments, and how can that be met? At what point should you say to the juvenile courts, "This is not your job, this is not a judicial function"? At what point can you say to the juvenile courts, "This is not within your competence"? After all, judges, too, have limitations. Juvenile-court judges, by and large, are usually limited when it comes to social case work.

Another problem is that in some parts of the country you will find voluntary agencies saying, "Now that the Government has come in, let them do all the 'dirty' work and we shall confine ourselves to a nice, neat little job, let's say foster-home care only. Everything else the Government is welcome to. We shall do only the highly technical job, the kind of job for which Government is not fitted, something that is very fancy." Such agencies desire to withdraw into isolation. Well, how safe is that? In my humble opinion, such agencies make a great mistake, not only because it is poor social work, but because you cannot do foster-family care without doing all of the other things that go with it, namely, work with the child's own family at every point.

It is a great mistake from the point of view of the agency as well. I believe that our institutions are in the plight in which they find themselves because of their isolation. And now, if child-placing agencies are going to confine themselves to one small bit of fancy work such as foster-home care, they will soon find themselves in isolation and out of the running. I believe that it is a mistake for any agency to do that.

Obstacles that confront everybody in social work are the realities of the situation, certainly the realities of economics. We say that all of these things need to be done in child-welfare services, but how are we going to get them done? Some people would like to solve their problems by putting all neglected children into adoptive homes or free homes. Social workers know that that is a violation of very fundamental human rights, namely, the right of kinship ties. It seems to me that we should be able to put across to the public the principle of preserving kinship ties and that we should be able to have it accepted. It is not possible to preserve kinship ties by placing children in adoptive homes or in free homes. But the realities of economics are on the side of the people who would like to solve the problem in that way.

Then there are people who have very little use for, or very little faith in, professional services in connection with child placing or in connection with the selection of foster families. Some of these people say time and again: "Well, what else do you want to know other than this is a good Christian family—that this is a religious family with good intentions—and that it is altruistic? Why do you need social workers to make an investigation?" These people are naturally not conversant with the history of child placing in America or they would not say that. Those of us who are conversant with that history know that these things have been tried and that they do not work. We know that child placing cannot be done on faith alone or on the basis of good motives alone. We know that caring for other people's children requires more than religion. The religious motive is essential, altruism is essential, but you need more than these in a satisfactory child-placing job.

We know that some of the best families, families that will meet every requirement as a family, will not make satisfactory foster families. We social workers know that, but the average person, the average citizen, does not know it; and it is up to us to put that idea across. Plenty of good families will not do as foster families. The protection of other people's children in homes of strangers requires professional service and the interest of governmental authorities.

In conclusion let me say that the areas in which child-welfare services are being demonstrated are virgin soil. You are there because there is so little in these areas; and the question arises, What is going to happen after the demonstration is finished, after you have left? That depends on what you are going to demonstrate. As far as foster care of children is concerned. the demonstration may be over before the placed child grows up. The demonstrations are most valuable in preparing the ground and in creating an atmosphere favorable to social service. These. it seems to me, are the primary objectives of the demonstrations. But I do not think that is enough. No matter how well you have done your job, no matter how well you have demonstrated needs and utility of social services, and no matter how well you have prepared the ground and the atmosphere, if you withdraw from any of these areas that belong to the poorest, the likelihood is that in a comparatively short time much of what has been accomplished will be undone. That has been our experience with relief when the Federal Government withdrew. Many communities dropped standards and went back to the conditions that existed prior to Federal assistance.

After all, we must not ignore the economic realities in many, if not most, local rural communities. These people are not worse than the people in the large cities or in wealthy counties, but they are poorer. The demonstrations should demonstrate not alone the inequalities between communities and the unequal distribution of wealth, which all social work does; they should not alone demonstrate the unequal opportunities to be found everywhere; but they must show the values of competent social service. It is my belief that permanent services cannot be assured without continuous Federal help. Even if you succeed in "selling" child-welfare services, the demonstrations will show, I believe, that many communities cannot carry on alone and often they cannot carry on even with the help of the State. To protect the demonstration it will be necessary for the Federal Government to stay in.

The Chairman. The first person on the list for discussing some of these problems is Mrs. Ann Botsford Bridge, of Maryland.

Developing Community Resources

By Mrs. Ann Botsford Bridge, *Social-Work Consultant, Child Welfare, Maryland Board of State Aid and Charities*

Initiation of foster care in our rural counties demands special skill, even though the worker may have had experience in the foster-home field. The most difficult problem that confronts the workers in rural counties is arousing the community to a nonacceptance of some of the things that have been accepted over a long period of time.

I am thinking of rural counties in which the child-welfare worker attempts to initiate foster-care services and is met by the response from the community that, after all, nothing can be done about the situations that are in the greatest need of having something done about them. After all, they say, that is the way these people have always lived, it is the way they always have been, and there is not much you can do by taking the children out of their homes and placing them in foster homes. The complete acceptance of that point of view is, I think, one of the hardest things that the child-welfare worker has to combat.

Mr. Kepecs spoke of the realities of the economic situation. These realities are very difficult and present a problem in the matter of continuing the program after a demonstration has been made. We have said a great deal about community participation, and it has become pretty trite to say that we must have community participation if the program is to continue. One of the ways in which the child-welfare worker can best help the community is by not undertaking to do the things demanded at the beginning, but by helping the community to build up its own resources with the aid of what the Government agencies can do.

A situation by which I can illustrate my point is one that happened not long ago in one of the counties in which we have a child-welfare worker, where a rather isolated and self-satisfied community worked out an interesting development. In that community, which was rather small, and in which homes are somewhat far apart, a number of old families lived—good, substantial people who were pretty well satisfied with the ways of their community. Into this community there moved a family consisting of a father, a mother, and eight children. Things began to happen that brought the people, the respectable citizens, to the door of the welfare department demanding that something be done. There was some thievery; there was a great deal of disturbance in school because the children of this new family did not behave as the other children behaved, and there were a great many things that irritated the old residents. One was that the father of the family was alcoholic and did not have a steady job. Several citizens demanded that the family be removed and the children taken away—out of sight, out of mind. The child-welfare worker who went into that situation did not immediately respond to the demands of the community but began to look at the community itself and to try to get the respectable citizens who had made the complaints to see what perhaps might be wrong for those children in the community itself.

To make a long story short, they began to be concerned about their own community, not only for the children who had moved in but for their own children and for themselves, and they did get together and discuss what might be done. They managed to establish a very interesting association for which they have quite a long name which ends in "Civic Association," and they are now trying to provide a richer community life which will give assistance not only to the children in that community but to the community itself. They have succeeded in building a rather fine recreational program which started from the complaints about this one family.

There is one other point I should like to make, and that is, if we are not to continue to be what Dr. Plant referred to as "glorified scavengers," it seems to me that we need to find a really new philosophy of both content and method in doing something about the conditions that produce the breakdowns in family life. I am thinking of the economic environmental factors. One of our child-welfare workers was asked a short time ago what was the greatest need in her child-care program. The first thing on her list was good roads, which seemed to be quite unrelated, perhaps, to the program, but she was pointing out that, after all, even though clinics were adequate and other resources in communities were adequate, unless there were good means of transportation in the county so that the people could make use of those resources there was not much use in talking about the building up of foster care and other facilities.

The Chairman. The next discussant is Miss Grace M. Houghton, of Connecticut.

Cooperation With Private Agencies

By Grace M. Houghton, *Director of Child Care, Bureau of Child Welfare, Connecticut State Public-Welfare Council*

I am going to approach this discussion from the standpoint that Mr. Kepecs spoke of, the relationship to the private agencies already in the community. Because of that point of view, the first thing the supervisors who had been appointed to the district work did was to meet with representatives of these private agencies, in order to show them that we were not going to get in on their job but to ask them to get in on ours. We realized at first that we could not possibly do foster-home care, since no funds were provided by the Federal Bureau for the purpose and we were not in a position to provide such funds.

We met with the three State-wide child-welfare organizations, and they all offered their cooperation whenever cases came up that needed their care. Then came the question of financial support. Connecticut has peculiar laws, as most of you people know, but one law which seems peculiar has been of great help to us in dealing with the private agencies. We may call it subsidizing, or we may call it compensation, but anyway the State is able to pay through the towns for seven-tenths of the cost of maintaining children who may be placed by private agencies. In that way we have been able to ask the private agencies to give us foster-home care when it has been necessary, and they get full reimbursement—three-tenths from the local town and seven-tenths from the State. Whether this is an advisable situation or not, it has been helpful. I think it is open to discussion, and I hope very definitely that somebody will challenge it.

Connecticut licenses all homes that care for or board children. The State Department of Welfare issues licenses to homes after they have been inspected and approved. These homes are licensed for a specific number of children and are under constant supervision. Child-welfare services have offered to supervise children placed in these licensed homes in the rural communities where we are organized, and in that way we not only have been able to safeguard the placing of some children by parents who are just shunting their responsibility but also have been able to get into the history of the children who have been placed more or less for adoption without sufficient investigation of their suitability for adoption. And in that respect we have been able to utilize the Yale University Clinic for studying the children who are placed for adoption. This, in general, shows our use of the private agencies for foster-home care.

I should like to give you a few instances of cases in which we have had to use these facilities. I am not going back into the reasons for their coming to us, particularly, or the steps that we took preceding our request for foster-home care, because it would take too long.

But just try to imagine that the child-welfare services have done everything in their power before they asked for foster-home placement. This is the case of a boy 9 years of age, a member of a family of four children. The father and mother were separated, and the father and two children lived in Maine. The mother had one boy with her and the boy we are speaking of had been left in a foster home. The boy had a reading disability. He had gotten beyond control of the present foster home, and the request came from interested people to us to do something about the situation. We took the boy immediately to the State psychiatrist, who said that he had been totally rejected by his own family and now by the foster family because of his behavior problem. What he needed, if he could not have his own people, was to go back into a foster home where he would have care, affection, and understanding. We were able to locate the father in Maine, and, incidentally, to have the girls, who were improperly placed, placed in proper foster homes in Maine. The father could not assume care of the boy, so the Connecticut Children's Aid Society came to our rescue and placed him in a foster home, where we have him under supervision.

We had a case of a widow who was on widows' aid. She developed tuberculosis and some plan had to be made for her and her four children. She was immediately hospitalized and two of the children, who were diagnosed as tuberculosis contacts, were placed in a foster home. The other two children were placed in Highland Heights, a Catholic institution in the area. By making these foster-care placements through private agencies it was possible to avoid commitment to the State, which might have resulted in a permanent break in the family relationship, because under our laws children remain State wards until they are 18 years of age. If those children had been committed, the mother would have felt definitely that her illness was something besides a physical disability; that it was a reflection on her character. Therefore, we felt that the less permanent foster-home placement was much better for the mother's morale. She has come out of the institution and is working. Definite plans are under way for this family to be gathered together again as soon as her health permits.

The child-welfare-services worker felt elated when the judge asked her what could be done to help a 16-year-old boy who had been brought to his attention with the idea of having him committed to a correctional school. The boy had been stealing. He was maladjusted in his home, which was a broken home, and it seemed that foster-home care would perhaps not be the thing for him, since he had been so long without proper home treatment. He was of fairly good intelligence and needed something by way of trade training. We have a Junior Republic in Connecticut which does a rather good job of adjusting our boys and fitting them for trades, but the problem was where to get the $500 needed to keep him at the institution for 2 years. The boy's stepfather was very much interested. He could raise about half of the amount, the Junior Republic agreed to raise some of it, and the town of settlement is paying the rest.

In one of our districts our worker is a trained nurse as well as a social worker. She was called in on a case of a girl whose physical condition was poor. The girl was drinking quite heavily, although she was under 14 years of age. She was also suffering from severe headaches. Apparently it never occurred to the local authorities to have a physical examination made of this girl. Our worker recognized the need, and as a result a physical examination was performed immediately. She required immediate hospitalization to prevent diabetic complications. Following her discharge from the hospital it was necessary to plan for her because she was out of her own home. A fine foster home was made available by the home-finding department of the State Child-Welfare Bureau, where the foster mother was able to provide a proper diet and give her insulin treatments. The child-welfare-services worker is supervising the case and the town is paying the full amount for the cost of her care.

The CHAIRMAN. While Miss Houghton was speaking I saw Mr. Bane enter the room. Mr. Frank Bane is executive director of the Social Security Board, and I believe he came to say something to us. Mr. Bane, would you mind stepping up here and giving us your message?

Mr. BANE. I deny the allegation. I did not come to say anything to you. I just came to see what you were doing, and I notice from the program I am approximately 24 hours behind time. Yesterday afternoon you were discussing child-welfare services and aid to dependent children and their relations. However, since I am here I should like to say that we have been operating now for something like 2 years on this general program of child-welfare services on the one hand and aid to dependent children on the other. We have been operating so closely, as a matter of fact, that I have had great difficulty upon occasions in telling which was our staff and which was your staff. And I am quite certain that upon occasions Miss Mary Irene Atkinson has had the same trouble out in the field. We have tried to tie together in the States, and tie together here in Washington also, child-welfare services and aid to dependent children. They are two parts of a more or less coordinated program. We have, as you know, a few problems left in the States. We have every State in the Union now with programs of aid for the aged. We have only 40 States with aid for dependent children, and we have another interesting situation.

We have, insofar as appropriation is concerned, all of the money we need and more for aid to dependent children on the Federal level. Last year we had an appropriation of something like $35,000,000 of Federal funds to be used to match State funds for aid to dependent children. We did not use half of it. This year we have something like $46,000,000, and we will have a balance of approximately $25,000,000, I think, at the end of this fiscal year in that program. Now, that may mean one of two things. It does mean, of course, that all the States are not as yet participating in this program, and we are very anxious to have all States participating. It may mean, on the other hand, that in many of the States aid to dependent children is not being administered in as adequate fashion as we would like to have it.

There was a clause in the original bill of the Social Security Act as submitted to Congress which said something about standards. That little phrase did not stay in the bill, and so the problem of adequacy of care is a problem to be determined by the States. The type of care is largely determined by the States, and the type of its administration is, to a large extent, also a matter to be determined by the States.

So the Social Security Board welcomes, in fact urges, all of the assistance we can get from you who are interested in child welfare in getting all of the States to cooperate in this general program and in persuading and urging the States to maintain this service on a more adequate and on a more constructive basis.

The CHAIRMAN. The limitations placed on Federal funds for aid to dependent children have a great deal to do with the difficulties found in these demonstration areas. They work great hardships on these various areas in which you operate which are the poorest, and I am quite certain that Mr. Bane would like to do away with these limitations, as far as the agencies are concerned. I think we ought to work for a removal of those very great limitations which are responsible for the accumulation of all of these millions in the Federal Treasury.

The next discussant is Miss Alice C. Haines, training supervisor of child-welfare services in Florida.

Initiating Foster Care in a Local Community

By Alice R. Haines, *Supervisor, Child-Welfare Services, Department of Child Welfare, Florida State Welfare Board*

Florida, stripped of the glamour of tourist spots, the fragrance of orange blossoms, and the romance of the South, gets down to the stark reality that children in Florida have needs just as serious and just as pressing as do children on the West Side of Chicago. Our country slums produce serious problems just as cities do.

I think perhaps the circumstances under which a child-welfare unit initiates a foster-care program are not particularly different from the circumstances under which it initiates a child-caring program in a community in which the child-welfare service is completely uniform. That is, it has required first and foremost and all of the time continual interpretation to the community of what we plan to do, what we have to do over, and how we can work with the community and through it in accomplishing our aims for children.

Hillsboro County, with Tampa as the county seat, was selected at its own request as a demonstration center for the beginning of a training program of Florida girls in children's case work. Hillsboro County had really very little conception of children's case work. The job that we had to do has resolved itself into four phases: First, interpretation of the meaning of a children's program; second, the actual development of a children's agency in order that we might have an opportunity to give training and demonstrate to the community the real need for the continuation of children's services after the training center was discontinued; third, the building up of a foster-care program (and by that I mean very largely a boarding-care program), because that was one of the points on which our program was sold to the community before we began to function; and fourth, the financing of our program.

The previous facilities in the community for care of children who had to be removed from their own homes consisted of four institutions and three boarding homes supervised and licensed by the child-welfare department of the State. These boarding homes were licensed to take care of a certain number of children. They were visited regularly by child-welfare department workers, but children were placed by any individual or any agency in the community that felt that a child needed to be taken out of his home and that money could be obtained to pay for his board. There was no attempt to place a child in a home because the child had a particular need or because that home had a particular service tô render that child.

The task of interpreting to the community what we meant by real foster care and what a boarding home might have to offer a child was not particularly difficult. We did not feel that the private agencies, the juvenile court, or the community thought that we were usurping their jobs or threatening their position in the community. They welcomed what we had to offer. We did not have particular difficulty in finding some funds with which to place children, although they were not sufficient. We had a total of about $3,000 for boarding care with which we have operated in the 15 months.

Finding boarding homes was our difficulty. We had the children, we knew the type of home the child needed, we knew what foster parents should offer the children, we had the money to pay the child's board, but we could not find the home. It took us weeks to find the type of home we needed for a particular child. We used every known method in obtaining leads for foster homes. That is, every method short of publishing the child's picture and giving his name and telling the pathetic details of his story, which our local newspapers would have been glad to publish. But finally we found one home which we could accept, which we felt had a great deal to offer the child; and from that beginning we have found additional homes. But one of our difficulties has been the finding of sufficient homes without the help of an official home finder to devote a great deal of time to building up for us a list of acceptable homes.

With our 3 trainees we have been able to find 13 homes and we have placed 55 children and possibly we might have placed more children had we had more homes and had we had more funds. But perhaps it has been a healthy thing for us because we have used all our skills and all our resources in developing home ties for the child and in finding family ties for him, whereas if we had had more homes and more money we might have been tempted to give up a little more easily.

Mr. Kepecs has made the point, which I think has perhaps been the most difficult for us to face, that our position in the community is one of impermanence. I think we felt a little less secure, a little less permanent in our community than the other demonstration units.

The placement of children often anticipates a period longer than a year, and in our local problem, particularly in the foster-care program, we have felt a lack of confidence in the real value we could be to the community. This was particularly true when two private agencies in the community, which were operating institutions for the "temporary" care of children, which in some instances meant 2 to 4 years, welcomed our presence in the community and wanted to make use of our help in closing their institutions and in making more acceptable plans for their children. They hesitated very decidedly, however, before they made the final decision to close the institution, because they did not know how long the training center would be available. However, in our preliminary conferences with the agencies it was possible to work out plans for all but 4 of the 32 children in the 2 institutions. These 4 required foster placements. However, the boards of the 2 agencies had enough confidence in the ground work that had been laid and in the ultimate ability of the community to take over the financial burden, to accept our services and close the institutions.

The CHAIRMAN. A great deal of care goes into the selection of homes, and for your encouragement, Miss Haines, and for the encouragement of others, I should like to say that agencies that have been doing home selection for decades perhaps have just as difficult a time in finding homes as you have in Florida, where you have just started. Mrs. Helen C. Swift, supervisor for the Division for Children in the Washington State Department of Social Security, is next on the program.

The Problem of Foster Care by Juvenile Courts

By Mrs. Helen C. Swift, *Supervisor, Division for Children, State Department of Social Security, Washington*

We were told what part we were to discuss and what we were to contribute to the general thinking of our program this afternoon, and I have been asked to tell how we got the results we did in Washington. I am really frank to say that I do not know how we have accomplished what we have. It is one of those intangible things that do happen sometimes when we go about searching for certain things that we want to accomplish. We set our goals and our aims and we are determined that we are going to reach them if it takes from 5 to 25 years, and we do not know just what one thing has contributed to that final result.

In attempting to bring to the judges of our State a knowledge of our ability to do the work we planned, we impressed upon them our sincerity in trying to be helpful and our desire to give them service and to understand what we had to give them. I believe that those things are the intangible things that have contributed definitely to the final result.

If you could have seen our State before 1935 you would have seen a typical old juvenile-court law that is still on our statute books. The first attempt at this sort of thing did not give us much encouragement. In 1933 we created a division for children in the State Welfare Department, but it did not function then. It did not have enough money; in fact, only $1,500 was appropriated. But in 1935 the State Department of Public Welfare was created with its different divisions carrying on all of the public-assistance programs, including a division for children; and in 1935 the Federal Social Security Act was passed. That was the beginning of the planning and the beginning of an opportunity to really begin to plan. Our juvenile-court law provides for a juvenile-court judge only in counties with populations of 30,000 and over. We are a rural State. We have only one million and a half population, but there were only 12 counties where we could have a juvenile court and actually only 5 counties with special juvenile-court judges.

We have four functions in our State child-welfare division; namely, aid to dependent children, child welfare, crippled children's services, and licensing of private agencies and institutions. When we put our program before the judges they asked us to put in writing what we could do. We agreed with the judges on two points—the type of cases that would come into court and the type of cases that we would handle. We agreed that we would take care of the cases that did not need court action. They conceded that care of dependent children was not a judicial function, and we agreed to handle all dependency cases, including those of children needing care in their own homes and of those who must be cared for away from their homes. We agreed that we would ask first the private agencies to care for the children who needed temporary care and would ourselves take care of the long-time cases. We agreed with the agencies that if they had the type of service needed for a particular child we would pay for that child on a per capita basis. Then we said the cases that needed court action would be those that needed change of custody or guardianship.

As a result of these agreements no child is committed to any agency or any institution for which the county welfare department is expected to pay unless the arrangements have previously been made by the court, the private agency, and the county welfare department, because before this the courts had been sending the children to the private children's agencies, the county paying for them on a flat grant.

The Chairman. I am now going to call upon Father McEntegart, of the Catholic Charities of New York.

The Broader Scope of Child-Welfare Services

By the Rev. BRYAN J. McENTEGART, *Director, Division of Children, Catholic Charities of the Archdiocese of New York, and Member, General Advisory Committee on Maternal and Child-Welfare Services*

We should all thank the Children's Bureau for bringing us together for these few days. As we sit in our own home town and read the papers, we hear much about reorganization of this department and that department. Well, at least two Federal departments are working together pretty well—the Weather Bureau and the Children's Bureau. On the other hand, we might pass a motion condemning the Department of Agriculture for bringing out the cherry blossoms before we got here. That should have been held up for our meeting and we hope it will not happen again.

The meeting has been a real success so far, I think, because it was so well planned. The reports given to us were very well done. Speakers from different parts of the country have given us a broad picture of activities.

Time and time again when I came to Washington, I have thought that I was looking over the map of the United States. That is the impression you get when you listen to people from various States. You begin to realize how different are the problems of various sections. When you are close to the picture at home, you think the rest of the country is just the same. But when you get out and hear a speaker from Nevada with 110,000 population describe how a social worker has to go from one end of the State to the other over mountains and deserts, and tell you that the biggest city has a population of 20,000 and that the others run from 10,000 down, you begin to say to yourself, "Well, conditions differ greatly in various parts of this country." Then you realize the need and the wisdom of that policy which Miss Lenroot announced yesterday morning—the flexibility of the program as administered by the Children's Bureau with no attempt to rigidly set down one uniform method of doing things.

The breadth of the program was clearly set forth by the speakers. The number of things that have been done and are being done made me feel that some of the hopes which child-welfare workers start out with may well be realized even during the span of one person's life.

In the White House conferences we dreamed many dreams. I want to add the White House conference reports of 1930 to the books that Mr. Kepecs would like all child-welfare workers to read. If you read the conference report on dependency and neglect, you will find that the committees believed child welfare was something broader than just foster care and that child-welfare workers needed to be more than case workers.

They thought of child welfare as comprising the welfare of all the children of the United States. You will find that they attempted to lay down a children's charter of rights for every child, not for one in a thousand, or for two in a thousand, but for all. That report gave a broader vision to our child-welfare workers.

When we came to the dependency and neglect part of it, I will never forget how J. Prentice Murphy worked on that. With all his heart he wanted to emphasize the prevention of dependency and the prevention of neglect. If you are going to prevent dependency and neglect, something must be done that is beyond the scope of the case worker. The deeper economic and social causes must be reached. We tried to figure out how many industrial accidents there were in this country and how many automobile accidents and home accidents and how many children those accidents deprived of their parents, and we asked child-welfare workers to take a vital interest in safety campaigns in industry and outside of industry and in workmen's compensation laws.

Other causes mentioned were sickness and insanity. If I remember rightly, 330,000 people were then in insane hospitals. How many of them were parents separated from their children? And how many children are in foster homes because of the insanity of parents?

Another cause was premature deaths of mothers. The statistics that have been brought out in the last few months by Miss Lenroot prove the great importance of preventing premature deaths of mothers at the time of childbirth and later.

We touched at that time on unemployment, on low income, and on the racial factors that were causing dependency and neglect. Throughout it all we felt that the social worker who was engaged in child welfare should be interested in the preservation and upbuilding of family life, not only by case work, but by removing the social and economic causes that tend to disintegrate family life. A good many of us came out of the White House conference feeling that the biggest job of a social worker is to prevent the disintegration of families.

After that White House conference there was a conference here in 1933 for child-welfare leaders of the whole country. The first item on the resolutions passed by that conference was the need of proper care for the 7,000,000 children then on the relief rolls.

When the advisory committee to the President's Council on Economic Security began to hand in memoranda for the Social Security Act, these were the things they were thinking of: The children on relief; the children receiving mothers' pensions (now we call it aid to dependent children); and the maternal and child-health program. Then, because private agencies and public agencies throughout this country were concentrated mostly in cities and in urban areas, it was felt that child-welfare services were needed to reach out into the rural regions and into areas in special need. Such child-welfare services could help to stimulate in those areas the forces necessary to supply proper facilities for childhood, the opportunities for the satisfactory growing up of American children, and the influences required to hold family life together.

And so these child-welfare services came into being. The reports given here show that those who have been appointed in the various States have caught the larger vision of child welfare. They have not confined themselves to foster care. But they have tried to integrate their work with the work of the aid to dependent children, with the work of relief, with the children's courts, with adoption procedures, with the intake of institutions and the supervision of the children afterwards, with training programs for those engaged in child-welfare work, and with the arousing of volunteer groups to take an interest in the children of the State.

I also caught a reflection of something that I consider even more important. Child-welfare services in some places are acting like leaven. They are influencing people in other fields of work. In the health field we have been told of many instances in which child-welfare services helped to start proper health facilities for the children of the whole community. They have stimulated proper recreational facilities, more adequate mental clinics, and institutional care of the feeble-minded; proper educational facilities and vocational-education facilities. I received the definite impression that the child-welfare-services worker is in fact a community organizer. That is a more important side of her job than tending to a few cases here and there. Such cases might absorb all her time. But if she can help to organize the State welfare department, if she can stimulate health groups, recreational groups, and educational groups to do a better job for all the community, she is carrying out on a broad scale the function that those who planned this program had in mind.

I believe that the flexibility shown in these reports is a real virtue. Nevada will not be like New York for a good many years. You will always need a different kind of program for Nevada.

Now, coming down to the matter of foster care. It is my impression that you cannot take any one arbitrary figure and say that if any community has foster-care facilities beyond that, it has too much foster care, or if any community has smaller foster-care facilities, it has too little foster care. You will find 250,000 to 260,000 children receiving foster care among the 130,000,000 of our people. That figures out two to each thousand people for the whole country. Now it is true that in certain sections special factors are present. The economic and social factors mentioned before, and others, may be concentrated in certain places. You will have to vary your index of foster care according to the conditions you find.

There is no rule of thumb by which you can settle the problems of the whole country. Some sections have too great facilities for foster care and others have too little. Let us remember, however, that for the whole country we have foster-care facilities for two children among each thousand people. In sections where there is too little, let us try by cooperative arrangement to plan out who will take up the work. Let us use whatever resources there are in that section and try to upbuild them. Let us not take the position that anybody who does not go along with the public official 100 percent is "blocking the Government program." After all, the people in this room are for the most part Government officials. These problems must be settled in thousands of little communities by people who are bankers, who are tradesmen, who are doctors, who are school teachers. The great bulk of the American people back in their home communities have to debate these questions and reach their conclusions. They are not "blocking the Government program" if, as members of a community, they insist on planning out for themselves a program that will suit the facilities, the traditions, and the personnel of their own community.

And, finally, I believe that where foster care is necessary it ought to be provided through existing facilities, improved and standardized if need be. Let us utilize what we have. There is so much to be done for all the children of this country. If we take the broader view that family conservation and family upbuilding is the major task of child welfare, and that the removing of the social and economic causes producing family breakdown is also a part of our task, we will not lack great opportunities for service even though foster-care facilities may be sufficient in our districts.

Wednesday, April 6—Morning Session

I. DEVELOPMENT OF LOCAL RESOURCES FOR CARE AND PROTECTION OF CHILDREN

Mildred Arnold, Director, Children's Division, State Department of Public Welfare, Indiana, Presiding

Miss Atkinson. We knew that the meeting yesterday afternoon would have to be cut fairly short, and we thought we ought to plan for a continuation of this meeting on the question of development of local resources for care and protection of children and again touch on the relation of child-welfare services to foster care. We have asked Miss Mildred Arnold of Indiana to assume responsibility for serving as chairman at this meeting. I think there will be an opportunity for a discussion of some questions you had in mind yesterday afternoon but had no opportunity to discuss. We want to divide the time, however, so we can at least begin on a discussion of case records in a public children's agency. We know there will not be an opportunity to finish that subject either, but we believe in this morning period we can at least get it opened up.

The Chairman. As Miss Atkinson has pointed out, we have had two things in mind in arranging for this meeting: To carry on yesterday afternoon's meeting—and I am sure there were some very interesting questions raised on which we would like to have further discussion—and to have a discussion meeting. This may be the last opportunity you will have to tell us of your accomplishments, and I think it is a healthy thing to have an opportunity to talk about all the accomplishments sometimes and also to raise certain questions you might have in mind.

The first topic will be the development of local resources for the care and protection of children, and that goes over to the discussion of yesterday afternoon, which was on the relation of child-welfare services to foster care. The second topic is more specific—case recording in local public agencies. We are all interested, I am sure, in that particular subject.

Some very interesting questions were raised by Mr. Kepecs yesterday afternoon and some were discussed in part. One was, "How are we going to get private agencies to modify their program?" I think there is a great necessity for the modification of many programs of private agencies, and the State departments must take a definite part in working with the private agencies and helping the private agencies, in a joint effort to make the program fill in the gaps.

Another point raised was in regard to limitations of cooperation with juvenile-court judges. We are very much interested in that in Indiana now. A good part of our child-welfare program is centered around the court, and when we realize the number of judges we work with and the differences in their backgrounds and training—how many have not had an opportunity to have any help in the more modern principles of child care, and how much authority is centered in the court—we must do some serious thinking.

And there is the problem of withdrawing services from demonstration areas. If any State has done it, I wish they would tell Indiana how to do it. First, we should like to know how to withdraw gracefully, and then we should like to be sure that the services that we try to develop will continue.

Another thing: What is being done in the local communities to keep the child-service program before the local boards?

How can we give the local board a picture of accomplishments and problems? I wonder, Mr. Kepecs, if you would not like to say a few words, since we are carrying on from the program of yesterday afternoon before we start out with our discussions?

Mr. Kepecs. I do not want to take up very much time and would rather confine myself to a discussion of some of the points you think are necessary.

The Chairman. The first thing, the question you brought out yesterday, is how are we going to get private agencies to modify their programs? Will you give us suggestions on that?

Mr. Kepecs. It is a very, very difficult problem to tackle. I feel that the institutions in particular have isolated themselves. I feel that if the institutions had not isolated themselves from the rest of the social-work program, they would be in a better position at the present time to adapt themselves to services required of them.

Some institutions have not isolated themselves, and they stand out because they have been able to modify and adapt their program to newer needs.

Case-work services in any institutional or child-welfare program should be among the minimum requirements of State departments.

State departments that have licensing and supervisory powers should establish certain minimum requirements for all foster-care work, in regard to physical care, educational opportunities, health supervision, recreation, vocational preparation, and case-work services. These are essentials in the development of child life in foster care.

Wherever it can be done with the consent of the institutions, that should be done, but in any event they should be made to realize the importance of these standards. When nothing else will help, the State should exercise its power by saying, "These are the minimum requirements, and if you wish to operate you had better comply." I do not think it is very difficult to make boards see that they would be more useful to the community as a whole if they modified their programs.

The difficulty lies with the people who are attached to institutions—emotionally and economically. I mean the people who work in the institutions. And presidents are not less difficult in some situations. Sectarian agencies are particularly protective of their work. I have no specific suggestions in regard to the matter. I am trying to clarify the situation. The State departments will have to clarify the situation for themselves. They will have to determine how far they can go and how far they want to go. We should have a goal and a method of reaching it. We may progress only inch by inch, but unless we know what we are after it will be doubly difficult.

The CHAIRMAN. One thing I should like to ask you. You speak about the State department's requiring case-work service in children's institutions. I am thinking about the institutions that are very small and could never afford a full-time case worker. Do you think it is feasible to tie the case-work service up with the county department that is using that institution, for instance, or do you have any other suggestions for these small institutions—and there are many of them all over the country?

Mr. KEPECS. I believe that wherever possible institutions should employ a case worker. Where that is not possible they should make an arrangement with a case-work agency to attend to case work. They might pay for case-work service through a case-work agency. I should prefer if the institutions assumed responsibility for their own case work, but if that is not possible, it should be gotten somehow. The county welfare department might furnish case-work services. I should do that only as the last thing.

Miss MASON. I should like to second and emphasize the suggestion Mr. Kepecs made with regard to the approach to the institutions. Without a doubt there ought to be steady, friendly pressure brought on them to apply case-work principles.

Too often they have been left out of conferences or have left themselves out. The institutions will probably have to be more specialized in their work, that is, they will have to be more specialized in the type of service they propose to render in the communities and the State. Sometimes the executive of the institution is not very responsive, and pressure for cooperation may be brought on certain influential members of the board who may be approached and made to see the point. There should be a steady process of getting these institutions to study themselves and to realize that the good old style has passed out and that the average institutions must adapt themselves to a new day.

The CHAIRMAN. I think the suggestion is very interesting that institutions should decide what type of service they want to give and develop a program to meet those needs. I wonder if any of the States has been able to get the institutions to do that.

Miss BARTLETT (Illinois). We are very much concerned in Illinois about that question. We have been studying it from various angles. The first approach is the compilation of reports by child-caring agencies in the State. When we have analyzed the material that has come in, we hope to have a picture of child care in the State and also to know the gaps in the program.

We are attempting to work particularly with the small rural agencies. Our plan has been to have a consultant go to the small agency and discuss the whole program. We have also attacked the question through regional conferences. A series of conferences including all institutions in the State has just been completed. Board members and executives were invited, and discussion leaders were persons who believed that the institution has some place in child care. I think the institutions have been afraid that the new movement is going to put them out of business entirely. We have in the State people who can talk from experience and who can lead the group to see itself from the point of view of the needs of the whole State. Our second series of conferences will be on minimum standards.

The CHAIRMAN. Does anyone else have anything to say on this subject?

Miss MASON. From the standpoint of case work in the institutions I think it important that it be an integrated part of the institutions and not something on the outside. If case work is not really a part of the institution the situation is the same whether it is an isolated case-work department of the institution or whether case work is furnished by an outside organization, either a family or children's agency. I think the question of the board's participation is very important also. I have sat with a number of boards of institutions, and I have found that they spend quite a part of the time talking about finances and that for the most part they know very little of what is going on.

I think we as case workers have frequently failed in not knowing the institutions and their problems and exactly where we can fit in. We keep case work as something on the outside rather than help to integrate the whole thing and understand what it really means to run an institution and to live in an institution.

The CHAIRMAN. Miss Mary Lois Pyles, director of the Division of Child Welfare, Missouri Social-Security Commission, will discuss some problems in the development of local resources for child care and protection.

Miss PYLES. We might begin with the words of the Social Security Act itself. It seems to me that the statement of the child-welfare-services part of the Social Security Act "to pay part of the cost of district or other local child-welfare service in areas predominantly rural" requires development of local units. In Missouri we have 8 local units ranging from 2 to 4 counties in each unit, including 25 counties, in which some real program is being carried out locally for the care and protection of children. We begin with local financial participation ranging from $15 to $30 a month from each county for a share in the expenses of this service program. It is perfectly true that some of the counties have more money than others and should pay more for this local care than other counties. Two of the 25 are among the poorest counties in the State and are paying from $15 to $30 per month. This payment is made on the basis of its being a preventive program and a good investment for the future.

In our local units we have two counties carrying over unexpended balances from one year to another, and they could finance their program entirely if they were convinced of its value. It is our job, at least, to take the leadership in interpreting the program in the counties. If it does not seem worth while to the public, then we are probably going too fast, and we will not be able to build a successful and lasting program.

Some of these demonstrations have continued for a year or 2 years, and as we go on in developing child-welfare work in local units we should work toward increasingly local financial support. Now, a suggestion as to how demonstration units may become permanent and how we may withdraw demonstration. One county, after having a local unit for a year or a year and a half, felt, when making up its local budget in January 1938, that it did not have the funds to continue its small participation in the work and would withdraw. That brought a great howl from the community, from the women's clubs, men's service clubs, school, and so forth. Some school officials who felt that the child-welfare-services work was very helpful went to the town officials and the town called a meeting with the county officials, requesting that some way be found to go on. The result was that there is now a combination of local and private funds and public funds from the town and county, along with the State funds, that will continue the work of that unit.

Certainly when the counties have enough money they should take over the expense along with as much local participation as possible. We know that not enough possibility exists in some localities for financing the work, so we need in some places, perhaps, a State appropriation for child-welfare services.

Our State legislature meets only every 2 years unless the Governor can be prevailed upon, because of an emergency, to call a special session. It will not meet again until 1939. One and a half years ago there was some agitation in areas where we had local agencies for a State appropriation to make it possible for every county to have one child-welfare-services worker. That program would not have gone across then. A group in our State connected with the State advisory committee is anxious to see the program go across next year, but we doubt if the program has enough public interest as yet and also whether we would have enough facilities in the way of an adequately prepared personnel to carry out the program successfully. We want to go slowly enough to succeed in the long run instead of starting something which may not last. We have not been very definite as to how long a demonstration should last, but after this length of experience I wonder whether in the counties where we are well enough integrated into the thinking of the public and are well enough known and thought of it would not be well to start thinking and talking about how much they might be willing and think it worth while to spend for this sort of work.

Even in the areas where we are doing pioneering work, we do have some tools to use. We do have the kindliness and neighborliness and altruistic interests of rural people to offset the great unmet and unrecognized needs. Wherever there is an outstanding case it seems possible to get the public officials to respond. We are spending a great deal of time meeting Johnny Brown's needs, and there are a lot of other children who ought to have the same thing. We should have a general program to meet all the needs.

In the very rural sections we often do not have any agencies, either public or private. Where they do exist, it is sometimes very difficult to avoid duplication and to work together efficiently and economically. Often nothing is available but neighborliness and willingness to take care of individual cases that are more outstanding than others. I think one point we might be interested in discussing might be the combination of public and private interests and support. I shall read a summary of activities in one community which illustrates this.

Mrs. L., leader in a church group, called an informal meeting of two representatives from each of the churches to discuss the need for community interest and participation in child-welfare activities. At this meeting Mrs. L. outlined the work and functions of the child-welfare worker and stressed some of the local problems presented in carrying on the work. She brought up the lack of local resources available in caring for children, such as the H case, in which emergency temporary care was needed. Mrs. L. first became interested in learning about the child-welfare work in this county because she was interested in the H family, in which the mother was dead and the father in jail, leaving four children at home with no one to take care of them. She cited other families known to her and asked the child-welfare worker to tell the group of the problems coming up in her work wherein it would be very helpful for the community to give assistance.

Since there was considerable sentiment in the group for the establishment of a local children's home, the worker tried to stress the fact that we did not want to destroy family relationships, and that whereever we found anything hopeful upon which to build it was much better to try to improve the child's own home where he has the love and affection and the security given by a feeling of belonging which it is difficult to give a child in a foster home. The worker tried to interest the group in doing something for the child in his own home. After that, it was pointed out, a foster home occasionally is needed for a child or family of children almost over night, and some plan must be worked out so that a boarding home or other means of care may be available when needed.

First there was discussion of how we found homes, and it was brought out that those members of the community in the meeting who knew everyone better than the worker who came into the community only a year and a half ago would be a fine source of suggestions for such homes. It would save time, and better homes would be found, if people in the community would be on the alert in finding them. This brought up the question of financing these homes. One woman said children needed a home spelled with a little "h" rather than a big "H." They hated the thought of a "children's home." She is rearing two boys whom she adopted.

There seemed to be a difference of opinion about the desirability of boarding homes, and the worker pointed out that we had a State receiving home for children who need permanent foster care. Perhaps the question of responsibility for different kinds of child-welfare activities would be a profitable one to discuss. Is finding permanent substitute homes for children really a local responsibility, or should there be facilities for the finding of a home for the child who needs another home, perhaps an adoptive home, because his own family can never take care of him? To have a greater source of supply of homes than those that can be found in his own county? It was suggested that we might use the private and public child-caring agencies to provide permanent foster care, but even in places where we have such facilities temporary foster care might be more desirable for the child, keeping him nearer the family and community ties which we want to preserve and strengthen.

Several meetings of the group were held to decide whether the small community should have foster homes and/or an institution, and who would pay for the homes. The women called a meeting of the men's clubs and officials, and the result was that the group, representing a large number of voters, interested the county commissioner (or county court, as it is called in Missouri) in paying the board for children found to be in need of such care. This group, which had learned a great deal about child-welfare needs of the community and about the child-welfare work which could be carried on with State supervision and backing and resources by a worker who is jointly a State and local worker, became a county child-welfare council. We now see the interest of the community people in doing something themselves. They had utilized resources for the individual things needed by children to supplement what could be done by the general programs, the State and categorical relief programs, and the county financing of boarding homes. The members of the group wanted to continue friendly services such as raising funds in their own group to supplement the resources for dental care, providing dues and uniforms for Boy Scouts and Camp Fire Girls, and having a committee start a Big Brother and Big Sister activity. They worked out a plan for special education for some children from underprivileged families to provide training that can be given in their own homes.

The CHAIRMAN. Miss Pyles has given some interesting material on case work in the community. We will have our next discussant, Mrs. Doris M. Affleck, case-work supervisor of the Delaware State Board of Charities.

Mrs. AFFLECK. In considering this topic I should like to approach it entirely from a case-work or service point of view. There has been a great deal of emphasis upon the community in these discussions, and rightly so, since we are all dependent upon local support.

I believe we tend to swing from one extreme to the other in social work. Either one hears only about the individual and his importance quite apart from, or even against, any modifying community influence, or else one hears only about environment, standards of relief, and need of public support, and very little about the individual who is in need of all this. This conflict is inevitable, since both sides are fundamentally important for us all. It is, as Dr. Plant said in his discussion, our need to be like and our need to be different. At one moment we see only the individual, even as we tend to be individual and different in ourselves. At another moment we see only the group, as our need for social living and likeness asserts itself again. As social workers we are required to find a balance here of accepting both of these real factors, that of individual needs and that of the community.

I should like to develop this further by saying that effective case work is helping people to help themselves, and I want to make more clear that by this I do not mean what is so often heard defined as case work, namely, gathering social data, considering all the factors in the situation, and then making a plan. Rather I mean respect of another person's own strength and ability to make his own plan if he is helped to do this by a social worker who helps him to feel his own situation and the problems in it, but who really leaves him free to make a choice, even though this choice is not always perfect. Several people here have touched upon this. Both Mr. Adie and Mr. Ramsay mentioned the rights of clients and the value of the child's own home. I hope we are tending more toward this sincere belief in the strength of individuals rather than in their weakness.

This may seem far afield from our connections with our community, but actually it is vitally related. This same attitude of thinking that we know best and that we must educate or reform leads us into difficulty in groups.

I cannot help but question some of our intense efforts to make communities aware of their problems. This seems to be a first objective of many programs. I am not questioning the need for local support, but I am asking: Does it really occur by this method?

So often we approach our community with ready-made plans and assumptions that we know best, that we have all the answers. Is this not an intrusion and an insult to the strength and intelligence of a community just as much as ready-made plans for individuals? Could this not account to a large extent for the resistance and opposition to the professional social worker?

Of first importance in the development of local resources for the care and protection of children is a sincere desire to use our skill in the service of the community rather than in the domination of it. The problems within it are really not ours but theirs, and any change or solution must come from the citizens; with our help, yes, if by this we mean presenting facts we have found in our daily work, but not if by help we mean asking a community to accept our plans and learn from us. Learning comes only through experiencing, and then slowly.

Now, if we should be able to develop this really helpful professional attitude, how can the visitor concretely work with the community? I feel that it is only through her actual service job that this can happen. The case worker who has a real concern for children has to be interested first in the individual child and only secondly in the community as it comes into the picture of this child's needs. If her concern is genuine, then it is around this that the community is vitally reached, and here only is the real object in common between the agency and its locals. Otherwise, how can one hope to interest groups in general welfare? We all know it is through the individual case that people are reached, and for that matter without this the worker has no place in the community agency. It is her job that gives her the right to participate.

It seems to me that community support is given only when the quality of the agency job is good enough to deserve it and when the conviction of the importance of the job is so real to the staff that the community cannot help but feel it. It is not something that is verbalized nearly so much as something that is felt because of the far-reaching effects of the actual service job being done.

There is a vitally related question of how we can help or hinder the development of local resources by the kind of existence we have in rural areas. Again this goes back to the kind of job we are doing. The rural worker probably is asked to do every kind of service. If she is too obliging, will the community ever develop far on its own or take any active responsibility for the problems of its people?

Again I wish to point out that helpfulness comes through finding and holding to our agency and professional limitations. If we do only what we sincerely believe is within our job capacity, is this not a much more responsible functioning than trying to do many things that are needed but that the community alone can do? Is it not more sound to recognize our limitations and to believe that the community can and will develop to meet its own needs if we do not interfere with too much interpretation and control?

Along with this must go a measure of flexibility and a willingness to work with others. In defining our responsibility and not going beyond that, there is a chance for the community to take hold in the spaces we do not and cannot fill. This still leaves us much room for case committees, discussion of problems with interested or related individuals, and opportunities to present the facts. But the important thing is our recognition of our own place in the picture as being partial only, and this must be sincere.

There is only one other thought I should like to put before you. I wish there could have been time for us to hear more about the actual case-work thinking going into these programs, that we might have heard more of the reasons for developments going one way or another.

I hope we are setting up our plans not from the top down but from the client himself up, and that our administration is serving our clients, as far as possible, thoughtfully and sincerely.

The problem of specialization of services has arisen in Delaware as it must have elsewhere, and I am wondering what thought you have had about it. Of course, in large rural sections there probably is no choice as to whether one worker will do all services or whether they can be centered in different workers. For us division is possible, and in thinking it out it raises the question of what actually happens to the worker and the client when, for instance, the same person has to do child placing and supervision of children in their own homes. If you have ever tried this, haven't you felt a problem in it?

It seems to me that the aim of each is so opposite in principle as to require an almost impossible professional orientation in a worker. For instance, under child-welfare services the aim is to help preserve the family if possible; whereas in placement it is to help a family-separation process so that placement can occur without injury to the child. Now, how can one worker find it humanly possible to orient herself toward preserving family unity and at the same time toward separation of family ties and destruction of this unity? Both unity and separation are among our most powerful and elemental forces, and to handle either one helpfully is difficult enough.

Besides the problem for the worker, in a function of all-in-one, there is also a very real psychological problem for the client. How can a mother relate herself to a worker who represents not only assistance in her own home but also removal of her children from her? If the worker represents so much, so many functions that are in themselves contradictory, it is too confusing to expect any helpfulness to come of it, I believe. A client can work through a problem situation only when an agency service is sufficiently clear-cut to offer one particular kind of service which the client can know and then choose to accept and work with or reject.

Perhaps this again goes back to the concept that a limited agency function is the only responsible one.

The CHAIRMAN. I think one very important question has been raised here that is facing us all, certainly facing us in Indiana, and that is the problem of the distribution of case loads.

Can any of you contribute anything on that, or is that too big a question? I think it is a pretty serious one and one about which there is a great variance of opinion, one person feeling there should be a geographical distribution and another that the case-load distribution should be on a categorical basis.

Miss HOUGHTON (Connecticut). Connecticut is facing that definitely. Serious consideration is being given to the distribution of services on a geographical basis. One worker in a given area would be responsible for all services.

The CHAIRMAN. The same person would also do child-welfare services in general?

Miss HOUGHTON. Yes.

Mr. KEPECS. If the social worker has the qualifications indicated, she should be able to do almost anything—bring assistance to children in their own homes and at the same time give the mother enough support to see that she needs to be separated from her children. An ideal social worker, one who knows and understands human relations, should be able to deal with both.

In regard to intrusion into the lives of people and communities, it seems to me that where communities have not done anything without intrusion and have come to us for assistance, or for that matter if we come to them and offer our assistance, they welcome and look for some intrusion or leadership.

In regard to specialization, I believe that that depends upon the volume of work, resources, and the number of workers available. It is governed by expediency, in other words. When the work is large in volume and concentrated in areas, specialization seems desirable, but there may be a conflict between specialization of function and districting of territory. When the choice lies between territorial division of work and specialization, territorial division is to be preferred. With a small number of workers in an organization, I would rather have one person cover a territory and attend to various services than to have two or more persons going to the same district and pass the same door for different services. Good case workers should be able to deal with human relations of all kinds. But where volume of work is concentrated in relatively small areas, it probably pays to have specialists because you can develop certain judgments through concentrated experiences which are helpful in the specialties. Volume of work per worker is, of course, an important consideration.

It seems to me that in rural areas there will have to be considerable undifferentiated case work coupled with consultant services for special tasks. A program would not be sound without specialists, if only on a consultant basis. Child placing is a specialty requiring specialized skills, but I would take a chance with a good case worker doing placement work, provided that consultant service in placement work is available.

There is another reason why I am in favor of the same worker's doing many jobs—it is enriching and broadening, and the worker has an opportunity of acquiring an understanding of various phases of human relations. Confinement to a specialty over a long period of time is narrowing. In child placing it seems to me that the worker who helps the child in his home should be able to help him accept other forms of aid. I am inclined to favor undifferentiated case work.

The CHAIRMAN. Three important problems have been brought up. One is the volume of work. For instance, next July, in Indiana, the age at which old-age assistance is granted drops from 70 to 65, and we look forward to forty to fifty thousand applications. I am afraid child-welfare services in Indiana will stop until this is handled. Second, the requirements of our workers, and third, the requirements of the programs.

Miss DUDLEY (Maine). I am one of the people doing a miscellaneous case-work job within the child-welfare-services set-up, doing partly the regular State department job and partly local work, and also, as we have said in a kind of phonograph record speech—the speech you have to make over and over again to people—lending my hands and feet to the selectmen and court and schools in an area with just three or four towns. The whole population is not more than four or five thousand in my area.

I expected all kinds of difficulties, as one who was going from a specialized child-placing job into a miscellaneous job. But I think it has an analogy in the field of other professions. The doctor who has an interest in rural medicine and who comes from a specialized city set-up must deal with emergencies, appendectomies, skin diseases, and everything. It seems to me a question of whether you fit into the professional pattern of the community if you are going to be a help to them in the handling of community difficulties.

I have found the problem within myself that Mrs. Affleck mentioned. In one case in which it bothered me most, I was the person trying to keep the family together and the person trying to take them apart. I have seen them over a period of almost 2 years through a father's court experience and a mother's desertion, trying to keep the family together through the grandmother's death and all kinds of troubles. Finally the father, who was perfectly terrified by having the children taken care of by the State and was going to jump in the river and never pay a nickel, came to me a few weeks ago and said he would have to ask me where the children could go because he decided I had a good head.

The CHAIRMAN. What about those who are doing assistance work for the aged and blind and independent child-welfare service? The assistance work is so much greater than the child-welfare service. I am concerned as to whether the assistance program will not overshadow the child-welfare work.

Miss FRANK (Louisiana). I should like to hear from some one who is working in that kind of program.

Miss DUDLEY. May I say that in the distribution of administrative areas in the Maine set-up we have come to feel strongly that it has to be a small enough population area for general welfare services. I am not doing work for the aged and blind. My work relates to children and helping with general local relief. The three towns in the project are supporting the service to the extent of $1,150 a year, so they feel that it belongs to them. But in Maine we felt we could not extend our work over an area so broad that one person could not cover it in 9, 10, or 12 hours a day.

Miss Pyles. Even if the ability and skill of the worker should be taken for granted and if we feel that the worker could do a good general job in all its aspects, her ability to do it would also depend upon the size of the area.

The Chairman. I should be interested in knowing whether all these States are throwing the whole program together and dividing it on a geographical basis. Is any one doing that?

Miss Labaree (U. S. Children's Bureau). Don't we have to help people define what service is? Some one recently said to me, "Yes, we carry a number of service cases." When I questioned further I found that it was not the families receiving grants that were getting service but out-of-town inquiries that they were calling service cases. It seems to me that through our children's work we have an opportunity to define for them something of what service means.

Miss Frank. I should like to hear more about some differentiated case loads. All I have been able to gather is that an undifferentiated case load is better, but I am not clear why. You think of the W. P. A. certifications and the C. C. C. enrollments, and, as Miss Labaree points out, the service cases are cases that are not relief cases. I should be interested to know what thinking went into it when you say, "It is better."

The Chairman. Who can discuss that point?

Miss Steele (Georgia). I know the two arguments given in our State. One is that an undifferentiated case load is more economical to the county because mileage is saved, and the second is that it helps develop the worker. I want them to point out why it is better for the children.

Miss Frank. Do we want the development of the worker at the expense of the children, and could we say because an undifferentiated case load saves mileage it is in the long run economical to the State? I wonder if any group has given any consideration to that.

Mrs. Rankin (Texas). I should like to know why it is better for the worker.

Miss Hewins (Vermont). I was trying to make up my mind what our policy is. We have been forced by the exigencies of the situation to have one, two, and three combinations of this generic case work. I think from the point of view of the ultimate development of the community we can say it has helped us to have this generic case work, and that it specifically helps us in our aid to dependent children program, where within the last year or so the case loads have been reduced from—nobody knows exactly what—150, 175, or perhaps 200, to an approximate 90.

The exposure to the service angle which has been possible through general welfare services has sold the idea to the department, so that today aid to dependent children is on a service basis. Old-age assistance is not in the department of public welfare, and we do not have that to consider, but I think the undifferentiated case work has helped us in aid to dependent children, and I think it is broadening to the worker.

Mrs. Rankin. Doesn't this in some cases become a family problem with the unit really the family rather than the child? If you think of it as a family job, it becomes sound to me. It is a family job.

Mrs. Buckley (Connecticut). Of course, some of the other arguments used are that the special agent has about reached the limit and that the town officials are tired of all the different people coming in and spending a whole day. They are tired of seeing all the different people coming in about the different things, and they cannot understand why so many should come.

Miss Sundwall (Utah). We also do a generalized job in going into the counties. Our workers accept the families in which there are children's problems. Of course, our case work is limited, but we do the assistance job along with the child-welfare job. We are trying to fit our program to the needs of the community.

Miss Dudley. I am perhaps being misinterpreted in my statement of what a miscellaneous job is. A child-welfare worker can give service to children and at the same time take care of other assistance needed by the family, such as enrollment of a boy in a C. C. C. camp, or assistance of that sort. We do the job needed in the particular family.

Miss Labaree. Could I ask whether these people are supervised by the State, these different people for these different jobs?

The Chairman. That brings up the whole problem of State supervision. Do you want to have some discussion on State supervision?

Mr. Page (New Hampshire). I want to discuss the matter of State supervision. Beginning July 1, we plan to have the workers carry undifferentiated loads. We have done a lot of planning and have run into a lot of headaches. The question of supervision comes to me. What is the difference between supervision and consultation service? Do they overlap when you call your consultants to strengthen your local or field office? I should like to hear a little discussion on that point, because I think if you get that set-up on a district-office basis, when the worker is carrying undifferentiated loads, you are going to have a little difficulty.

The Chairman. I think Mr. Kepecs brought out the point of consultant service.

Mr. Kepecs. There are two aspects. One is administrative, and where State funds are made available it is up to the State to see that funds are spent well. The other is consultant service which may be handled in connection with administrative supervision or in connection with specialized services. I am not sure which. It is essential to find persons who can do these things. The State has certain administrative responsibilities in connection with maintaining minimum standards, and it also has the function of supplying consultant services in connection with specialties in case work such as child placing. Much depends upon the number of people that the State can afford. The State does not discharge its obligation unless it has someone to supervise and enforce minimum standards. Consultants and specialists are very desirable. I believe that they are essential. But it is a question whether the State can afford and can find such persons. It is not likely that the same person can function in both capacities adequately.

Mr. Class (Oregon). What do you mean by an undifferentiated case load? What are your criteria?

Mr. Page. I think of it, as has been mentioned here, as having the workers carry not only the categorical work—work for the aged and blind and aid to dependent children—but also being responsible for service work in relief families and for child welfare.

In New Hampshire relief is going back to our local officials. We work on a county and town basis, and I might say here that I think perhaps in New Hampshire we are different, but it seems to me we are having quite a change in thinking on the part of the general public as it sinks through their heads that no longer should they label relief legislation "emergency legislation," as they have done in the past, and as they realize that this will cost a lot of money and be a permanent program. We find taxpayers' groups being formed and examination of the way in which general relief and all other forms of assistance are being administered, and they are wondering if this is the better way of doing the job. All of this to me is very, very healthy.

Then, too, as happened recently, here is a little town overseer of the poor, as he is called in New Hampshire, and he has visiting him in 1 day seven people. He says, "What kind of service is this? I am a part-time official and I have to work, and I entertain seven of you boys and girls from the State office in 1 day." It doesn't make sense, and he feels it costs a lot of money. They traveled a long way and two went in to visit one family, one to see an aged person and the other a blind one. Money still talks. It is pretty close to the hearts of these people, and I think we will have to adjust ourselves to a situation which financially is very, very real, as well as recognize the social problems involved.

Then, too, as it becomes a permanent problem and is recognized as such by the people in general, we are having thrown up in New Hampshire fences that say, "You are not to go out of the State to get your trained workers." You have all heard that before, and if you are administrators it is a very real problem.

What that means is that when you start to take over an entire load, as we are going to do in New Hampshire in July because of new legislation, we are going to have to take boys and girls out of the State universities. They have been exposed to sociology for 4 years and they are sincere in their desire to go into public-welfare work, but they are not trained.

So to me the only hope of doing a fairly decent job eventually is to put into the key positions—on the consulting jobs and supervisory jobs—persons trained and experienced. If we can do that, I think there is some hope over a period of months of arriving eventually at a program that will satisfy the general public and will actually be doing something for the social needs of the people.

II. CASE RECORDING IN LOCAL PUBLIC AGENCIES

The Chairman. We must go on to case recording. Public agencies are interested in case recording. We in Indiana have recently checked over all court dockets in search of lost files and we found 1,500. One judge said, when he was approached, "No, you can't now, but I will let you go through the docket in a couple of months." We found that every afternoon at 1 o'clock he was shutting himself up in his office and getting the court docket up to date, and for the first time in the history of the county it is up to date.

Miss Bessie E. Trout, welfare-training assistant in the Bureau of Child Welfare, New York State Department of Social Welfare, will open the discussion.

Miss TROUT. Record keeping is one of the factors in our work that is general—at least the problems in it are. I am going to mention just a few of the outstanding difficulties we face in New York State before mentioning some of the constructive factors in the use of our records.

First, there is the heavy case load. In New York State we have usually one children's worker assigned for all children's work in the county. The average case load ranges from 90 to 100. If Mr. Carstens were here, he would probably say it is double the norm for a case load—if we have such a thing. The time element, therefore, is one of the first difficulties we face in social case recording.

Recently one of the county children's workers said that she had four records for me to read because there had been four Sundays since my last visit and she wrote all of her records on Sundays and holidays. Not all of our records are written on Sundays and holidays, but social case recording, by and large, has become something that does not have the importance of the rest of the job—something to be done after the day's work or when one has the least amount of pressure.

An associated factor is that pressure of work seems to create in the worker a habit of activity which tends away from the kind of evaluative, constructive thinking necessary to social case recording. It is easier to jump in a car and "do the job" than to develop the self-discipline necessary to good social case recording. I think we all would agree it is more important to do a job than to record it on any single occasion, but over a period of time this habit of activity is likely to become a state of mind.

Another difficulty (and it is in the working out of this difficulty that we can make one of the most constructive uses of the records) is the fact that we have not gained recognition of social case recording as an integral part of the responsibility for a child in a child-welfare program. The importance of statistical and financial recording is fairly clear, but that social case recording is a real part of the program is not recognized.

In the medical field recording is accepted; all doctors, nurses, and hospitals recognize that a record of the patient's daily condition may mean the life or death of that patient. The lay public recognizes its value to the extent that confidence is increased in a physician or hospital that keeps such records. A dentist over a period of years will keep a record of his patient's condition; and if he does not, we question his ability and perhaps consider a change of dentists.

I wonder how many of our public officials know that it is necessary in order to give adequate care to a child that we have a record of that child's experiences and development. We have the task of defining for our officials what should go into these records. We must know what has happened to a child. We need some perspective of the life experiences he has had—not only information about him, but what his experiences have meant to him, what interpretations have been given him, and how he understands them, as well as other factors in his life which represent so frequently the basis of his behavior and which we must know before we can understand how to treat him. Probably few of our public officials have any way of knowing the importance of having in a record the facts of the child's origin so that we may preserve for him the things about his family and about himself.

We need also to have made clear to public officials and board members that both the child and the foster parents can suffer a great deal from a change of workers that results in change of methods unless we have some record of the way in which the previous worker has treated the situation. Naturally, too, there is great loss of time when records are not kept, because each new worker must accumulate the knowledge already gained by the previous worker. In addition to loss of time there is annoyance to members of the community and to the foster parents or to the child in going over again the ground someone has already covered.

These are some of the difficulties. We come, then, to the use we can make of the record. The workers themselves are not wholly clear as to the use of the social case record. We need to do more work in making clear what should go into the record as well as what uses can be made of it. A record is a tangible thing. It provides one of the ways in which we can give the broad interpretation to our program, and we have many opportunities for interpretation presented to us.

Recently a county commissioner who was questioning the quality of work done by his child-welfare worker commented, "I don't know about her records, but I guess they must be good because there are pages and pages and pages of them." How could he evaluate his own work? He was reaching out to know what should be in the record. As we interpret what is important to the welfare of a child in the way of a record, we find we are explaining at least in part a child's needs and our responsibility in meeting them, as well as defining and clarifying the child-welfare program.

In considering another factor of the use of records, namely, the value received from rereading and evaluating for treatment, we must again turn to the medical field. A doctor does not see a patient without first glancing at his chart. All too frequently our children's workers file their records as a task completed and do not refer to them before visiting a child for the purpose of understanding what is happening to the child—learning what has already been done and how the child has reacted—and determining what the next step in the treatment should be.

It has been interesting to me in visiting the different counties to find that where there is poor recording there is generally a poor quality of work, and where there is the best recording there is usually the best quality of work. I do not know which comes first, but there is something in the discipline that causes the worker to look at what is happening to the child under her care, that causes her to stop and think (and those who keep the best records must stop and think), that brings a perspective and a stimulation which promote the growth and development of the worker—a value that we could interpret to our public officials.

There are so many ways in which we can use our records for broad interpretation of what child welfare is. I wish we could get together and work out methods that would be a little clearer to us.

Workers are all pressed for time—we find it necessary to talk about short cuts and to determine which things in our work we cannot do without. As we define more clearly the necessary content of our records and clarify our thinking on the broad constructive uses, we may be able to bring about changes, such as the lowering of heavy case loads, which would make more effective recording possible.

The CHAIRMAN. The discussion will be continued by Miss Frances Steele, director of the Division of Child Welfare, Georgia State Department of Public Welfare.

Miss STEELE. I am thinking in terms of my own State of Georgia in regard to the problem of records. Our main point is we have no protection for our records. The administration has instructed the directors that they must have the records open for the grand jury at any time. The newspapers have asked that the records be available in the courthouse and the name, address, and race of the recipient of aid. Those are the two main problems we have. Building from the programs of F. E. R. A. we have in every county folders for relief cases. Sometimes there isn't anything in the folder except the name and address and race, but the old W. P. A. Form 144 went a little further and actually asked for the occupation. Along comes child-welfare service, and our problem now is, are we going to give way to the temptation to lower our standards because we feel the pressure of lack of stenographic service and because many of the county directors have not gathered the idea of child-welfare service?

If we can get across to our boards and county commissioners the fact that a record does not hold a lot of secret and confidential information against a family but is our tool and guide, we will get further away from the idea that case histories have no real value. We have had no test yet of the child-welfare records, but, as I have said, in one county the newspapers demanded that they be public. When the test does come as to whether or not the records will be open to the public, we will have to work on the idea that they are not secret or confidential, as well as on the fact that they are the tools with which we work.

We feel that in these records it is our job to weigh and evaluate what the board and what the layman can understand, because in that way we can sell our program to the State and increase our funds. It is the only way I see that we can reach the people and our State and county officials.

In Georgia the old-age-assistance program has had so much emphasis that we have had to creep along on child-welfare services, and we have gone pretty slowly at times, but we have managed now to get the eye of the administration fixed on children's problems. If any of the rest of you have the problem of open records for the public we should like to know how you handle it.

Miss ATKINSON. Let me present to the group Miss Josephine Brown, who led us through the struggle in the F. E. R. A. program.

Miss BROWN. I have been much interested in hearing what you had to say and realizing what a fine lot of people there are doing the child-welfare job over the country. I think perhaps I am in a little better position to appreciate that than a good many people who came into the job fairly recently. You may be interested to know we did have a very serious test case on records in the F. E. R. A., and the

Federal Department of Justice was willing and glad to be called in. The rules of the courts in one or two cases have been that such records have professional status and they are not subject to revelation to the public in court or anywhere.

The CHAIRMAN. We are very glad to have this reassurance about what help we may be able to get in this problem. Mrs. Norma Rankin, director of child-welfare services of the Division of Child Welfare, Texas State Board of Control, will discuss the subject.

Mrs. RANKIN. Case recording is an all-important matter and one we have had considerable discussion about recently in our own staff meetings. I might say that as far as Texas is concerned it is of the open road and wide spaces. As one of our workers said in a meeting, "We have nothing and we need everything." So we must approach it at that point in Texas.

In thinking of this question I have analyzed it from several points of view, and one has been brought out in our set-up—the relation of public agencies to the State office from the point of view of record keeping and the effort to assist and facilitate office mechanics in order not to burden the worker with too much in the way of setting up procedures necessary to get factual data and data we need for relationship and research matters.

A county judge said, "What are these things you talk about as case records and what do you use them for anyhow? I have always thought the reason we have these records is so that the worker is given something to do in her spare time, so she will have an opportunity to write about what she has done in her spare time." Then he pointed to the confidential nature of the records and said, "You refer to the all-importance of the matter of your records. Do you permit any one to have the information, and what do you do with it after it is written?"

I think we have opened a new area in the use of records and interpretation to boards from the point of view of community case records, as well as case records of children. I should like to present very briefly some of the comments given by members of our staff who were discussing the question of case-record writing recently. In addition to the general phases we are all familiar with, our staff members have these remarks to make:

> The recent influx of out-of-State inquiries and cases of aid to dependent children has been a difficult problem to us in our county. Frequently the information given is vague, misleading, incomplete, and as a result our own reports on each case are necessarily inadequate.

> There is a lack of understanding of what we might consider the elementary rules for weighing the value or determining the usefulness of the data obtained. Often facts are unknown or information is misleading. If the principles of record keeping were clear to the social workers recording the information it would probably enable them to make more reliable inferences.

> The matter of inadequate case recording has been brought to my attention lately in endeavoring to assist this county in planning for cases of children supported by the county in some one of the children's institutions. There are no records regarding the parents, no listing of relatives, and no reasons given for declaring the children to be dependent and removing them from their own homes. It is evident that time and expense could have been saved had such information been on file, and certainly the county would have a more sound basis of explanation of the circumstances which warranted the action taken.

> I have been impressed constantly with the importance of complete and accurate case recording. In numerous instances I have been called upon to refer to the records in our office on points of discussion which have arisen with county officials, the county attorney, county judge, health officer, and others. In every instance the information as stated in the record in a clear and concise manner has been accepted as the final issue in the case.

Another worker brings out the point:

> Thinking a little beyond the mechanics of record writing, I believe the case record could be a real factor in the actual development of community resources. What better sources of information regarding interested individuals and community groups, sources from which funds may be obtained, and so forth, do we have than the records of contacts with individuals? It can easily be seen that a new worker going into a county in answer to an application or request for service could benefit greatly through first reading and analyzing the results of contacts made and cases recorded.

From the standpoint of the ethics of recording, the problem of confidential information is an important one. It is well for the worker to inform the client that it is necessary to make a record of facts. The worker may enter information in the record and place the word "confidential" before it. Often confidential information is given which has no bearing on treatment and therefore, in my opinion, might be omitted from the record.

A record is not objective if it includes only the facts that are favorable to the case worker, when possibly there are unfavorable elements which are also significant. Regardless of how the recording is done, we should bear in mind that the primary purpose of keeping records is to assist us in beneficial treatment of our client, and the record is most helpful when written in such a manner that it gives a clear picture of the child involved and his relationship to his environment.

I might say in summing up that my own belief in connection with record writing is that the record, in addition to being useful in the handling of the case with reference to the child, should serve as a competent qualitative measure of the shortcomings or ability of the worker.

The CHAIRMAN. The discussion will be continued by Miss Florence Mason, assistant director of the Catholic Charities Bureau, Diocese of Cleveland, and member of the Children's Bureau's Advisory Committee on Community Child-Welfare Services.

Miss MASON. When I think in terms of the case loads you must carry, I immediately realize what your records must mean to you; but all of us have the same problem of recording, that is, establishing the importance of records. Whether you have large case loads or whether you are from a well-regulated agency, you will find the case workers doing the work at night. Case recording has not been established as an important function of the agency. You talk about case loads in relation to your record writing. To sit down and dictate without a plan makes for some very long records that are not thought through. If you are to write a good record, you have to take time to organize your material. It seems to me that in child-welfare service you have an opportunity of establishing the importance of records and the significance of factual material, which no person in child welfare has a right to leave out. If you are ever placed in a position of having the children coming back and trying to find out about themselves, or of people trying to find out something about the children they have adopted, you will immediately realize the importance of that type of material. I often wonder what right we have to get the facts and not have them where they can be used afterwards.

Then there is the record of the child himself. I wonder if some problems could not be solved for a generic case worker if you had a separate record for the child, a record giving the picture of the child, the type of record you think of using as a tool for treatment. You could have your factual material in the general family record, and for each child a separate record giving a picture of the child himself, or what you know about the child, and what is being done for the child—the type of placement that has been made, what that has meant for the child, the things you have done for this child, and the child's relationship to the family. All this material would have to be pretty carefully worked out.

I was in an institution recently when two little girls, sisters, came in and were waiting for the head of the institution. The younger one was asking if she could go out and buy some material, a book helping her to design some things for a party. The older sister said, "Margaret doesn't like to draw as well as I do," and the younger child said, "Betty only says that because she draws better than I do, but she doesn't know what is inside of me." And I think that is the thing we must know in the records—what is inside of the children, something of the hopes and ambition of the child.

The CHAIRMAN. We have a few minutes left for discussion. Something came up in Indiana the other day that was very interesting. It concerned case reporting by a private agency to the State department. We have a new set-up in our State, and the executive director of one of the private agencies said they had sent in all the cards and all records except one. The case worker refused to send that one because it concerned an illegitimate child, and the paternal grandfather came from a prominent family of the city. She said the records were not kept confidential enough, and we could not guarantee that confidential material would be safeguarded. That is the old feeling that public records are public, and that is the reaction we are getting from some private agencies to those records. It involves two things. Do we have to give an assurance to agencies and people in general that public records are not public? Have you had such problems in your States?

Miss BROWN. I think perhaps one thing I worried about more than anything else in the F. E. R. A. days was what was being written in the record. I know a lot of people did not have time to write much of anything, but a great many workers who came from private agencies felt strongly about putting everything they knew on paper. I want to warn you again to ask your county workers to be sure they do not write anything in the records that they cannot verify; that they have not verified—gossip and judgments about people's moral character. Somebody said something about a child's coming back and wanting to know something about the family. Just suppose the worker had written something about the mother's character that she did not know as a fact. The case I spoke of a few minutes ago in which the Department of Justice came in was a suit against a worker for libel by a client, and I do not know whether the worker had verified the information she put down. It is possible to get into a jam by making unverified statements about people's mental condition and their moral character.

Mr. JONES. I should like to say something about records from the standpoint of an executive. I think I know as much as anybody knows about the inadequate-record story, because as the superintendent of an old agency I now have a continuing correspondence with people in all parts of the world in an effort to get factual information for many people who as children were sent West years ago. I could speak at length and eloquently about that aspect of the matter. I know the unfortunate results of not recording information about people. For example, at this very moment it is unfortunate, indeed, that I cannot give a brilliant young university graduate in the Middle West, who is about to marry a brilliant young woman, a few facts about his family background for the simple reason that these facts were not recorded when his father as a boy was shipped to a distant point. But this morning I wish to point out the other extreme—the long and overwordy record. This question of record is fast becoming a headache to many executives. A young woman in our office the other morning was referring a case. She told the supervisor and me something about the matter. The supervisor remarked, "Perhaps I had better drop in at your office and look at your record." The young woman said, "Well, there are 40 pages of it." After she had gone and I showed some concern over her evident idea that service is now being measured by the yard, the supervisor remarked to me, "Why, one of the students in training had to read a record of 80 pages the other day." A friend of mine, who is a supervisor in a large city, told me recently that her field visitors were averaging about 1½ hours in the field each day, and when I said, "What are they doing the rest of the time?" she said, "Why, processing their records, of course."

From the experience I have had in working with a scientist in another field, I have a conviction that we greatly overrate the social-service records as research material. They are not prepared under the conditions demanded by a scientist, and I do not accept at all the oft-repeated statement that these records are full of rich research material. As I read them, they very often go into long statements about what Miss So-and-So, the social worker back in 1915, 1920, or 1925 felt about Mrs. So-and-So as a good housekeeper, or a good mother, or something else of that sort. I read one of these records the other day in which six or eight different people had "felt" things about one person and another—page after page. I knew none of the people who had written this material, and no one who is at all scientifically minded could place very much value on such talk. Much of it should never have been recorded at all. I hope that you will not have such an amount of money that you can be reckless with it and go on spreading yourselves over acres of paper. The fact that you may realize that you may have to account directly to the public for what you spend and for what you say about people should be a challenge to you to get something done about records which has not yet been done in the social-service field. I could tell you of many executives who are becoming very much disturbed on this subject. Some of us cannot even hire room in which to store these voluminous records, which we might as well admit no one ever reads.

Now, please do not go away from this meeting and say that I do not believe in records. I do believe in records of factual material. I believe that you people who are gathered in this room can do something about this matter. You are young, energetic, and open-minded, and you have a broad view, and you are out before the public as public servants. You need not be hindered by the patterns that have set the minds of some of us. Can you not take up this record business and in some way see that records are brought into a limited territory and that they contain factual information, which everyone admits we need, and leave out emotional impressions as to whether Mrs. So-and-So was domestically inclined, whether her mother should have held her in a different arm when she gave her her bottle, or whether she should have let her lie in the crib? Let all that lie in the field of speculation, which for the time need not be committed to print. You may write articles about such matters and publish them in journals and there they may be rather harmless. Let us get away from the idea that civilization has to be saved by the typewriter and the mimeograph. What I have heard you saying here this morning is very important, and its importance could be emphasized almost daily in the offices of any of the old agencies. Often I am very dependent on a tidbit of factual information which may change a whole situation in life. A very simple letter of half a dozen lines, with an address, kept in our records for 20 years, enabled me to bring together a mother and son. This factual information was very useful in this situation. The business of how "she felt," "he felt," "I felt," and "the worker felt," did not seem so important after 20 years.

Miss TROUT. Miss Arnold, I think Mr. Jones has made quite a point. Especially during the last few years there have been differing opinions of what we should do. I wonder if it is in keeping to suggest that we have a committee to study further what problems we face and how to deal with them, and perhaps make something of what Mr. Jones suggests as to how we should do it.

The CHAIRMAN. What is the feeling of the group? We have been challenged now. I wonder, Miss Atkinson, if you would be willing to appoint such a committee, and perhaps, if we have a child-welfare conference next year, we can have the committee's report.

Miss ATKINSON. If it is the wish of the group, it seems to me the Children's Bureau could appoint a committee for the purpose of continuing to explore this topic and to get some material together which would be helpful to the various States.

I should like to refer to something Dr. Plant said one time to the effect that, in his opinion, a good many records were not records of children at all but were merely portraits of social workers. One time I had a worker on my staff who always tried to include his entire philosophy of life in every record he wrote. It was important to know his attitude toward the problems of children, but it was not exactly germane to the treatment of the child to make his pronouncements on social, economic, and moral questions a part of a child's record.

Mr. JONES. Have on that committee somebody who comes to it rather fresh. Got some one to come in absolutely new who will say, "Why do you do things this way?" That is the sort of person who usually makes a contribution to life.

Wednesday, April 6—Luncheon Session

DEVELOPMENT OF SERVICES FOR RURAL CHILDREN WITHIN A STATE CHILD-WELFARE DIVISION

C. C. Carstens, Executive Director, Child Welfare League of America, and Member, General Advisory Committee on Maternal and Child-Welfare Services, Presiding

Miss ATKINSON. We have asked Mr. Carstens, executive director of the Child Welfare League of America, to carry the responsibility for this meeting this afternoon, and I turn it over to him now.

The CHAIRMAN. The first responsibility I have is to present to you two resolutions that were voted by the Advisory Committee on Community Child-Welfare Services.

These resolutions you will be interested in, but you are not asked to take any action on them, because they have already been approved. The first one reads as follows:

Whereas a State or local public-welfare program is complete only as it makes provision for a broad program of service to children; and

Whereas the acceptance of this principle by the various States and by local units is necessary to full development of such child-welfare services; and

Whereas title V, part 3, of the Social Security Act, providing for child-welfare services, implies the continuous expansion and strengthening of community services for children: Therefore be it

Resolved, That the Children's Bureau, in cooperating with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, public-welfare services for the protection and care of homeless, dependent, and neglected children, and children tending to become delinquent, bring to the various States the necessity of making legal and financial provision for the whole program of child care and protection, so that its benefits may reach all rural and urban areas.

The second resolution adopted by the Advisory Committee on Community Child-Welfare Services of the Children's Bureau reads as follows:

Whereas a complete program of child welfare has for its most important principle the maintenance of the child's own home whenever possible; and

Whereas the limitations incorporated in title IV of the Social Security Act with reference to the amount of the Federal contribution and the amount of aid authorized for each child have resulted in a less rapid extension of aid to dependent children than has characterized the program of assistance to the aged and have further resulted in many children in receipt of aid having assistance so inadequate in amount as to fail to provide the minimum essentials of life: Therefore be it

Resolved, That the Advisory Committee on Community Child-Welfare Services request the Children's Bureau to express to the Social Security Board the committee's deep interest in the extension of the program of aid to dependent children and its opinion that the objectives of the program cannot be fully attained until the Federal Government contributes on as generous a basis as in the case of old-age assistance and assistance to the blind, namely, at least 50 percent of the total costs;

The committee believes further that an increase in the Federal Government's share in the program should be accompanied by requirements which would tend to assure the granting of aid in each case sufficient to maintain home life for children in accordance with minimum standards of health and well-being.

That gives me a very satisfactory text for my brief remarks. Our greatest living philosopher said at one time something that I think is also a text of value which we ought to keep in mind and which is a second text for me today: "What the wisest and best parent wants for his own child, that must the community want for all its children." That is a quotation from John Dewey.

We have been discussing during these 3 days problems that have related themselves mainly, in some way or other, to the tragedies of human life. I am interested not only in the tragedies but also in the prevention of tragedies, and therefore I should like during the few minutes that I have with you to point out that instead of having prevention always being merely the last work of our speeches, it should. perhaps, come somewhere along early in the game in our interpretation to the communities with which we work.

We should aim to have in our community organization provision for good health protection, for good schools, for good recreational programs, for good libraries, for artistic surroundings, for music that is elevating, and dance that is an expression of the joy of life; proper housing, proper protection against demoralizing conditions, a press, motion pictures, and all those things that make for wholesome surroundings and wholesome family life. This cannot be obtained in a day, in a week, in a year, or perhaps in many years, but I think we are derelict—you and I are derelict—if we do not somewhere in our day's work or our week's work or our month's work emphasize that prevention results from having many wholesome things in our community life rather than from any little formula that someone may spring upon the community and for which he takes great credit to himself and to the agencies. Prevention of dependency, neglect, and delinquency is a long road, but it is a road that each one of us and those who are connected with us must be invited to travel.

All this is implied in good community organization. There are a few things, it seems to me, that are inalienable rights that children have, and I have just selected a few. They may not be inalienable rights at all, but they seem to me to be. First, a good physical start in life; second, a home—emphasizing the simple mores of the community; third, a protection of the kinship ties and the right of a child to know who his kin are; fourth, an opportunity to develop the intellectual powers with which he has been endowed; fifth, help, if necessary, to find the niche for a useful place in the world's economy.

You have heard much about how we ought to deal with dependent, neglected, and delinquent children, but let us remember that we must make our contribution too, through community organization toward better things. Yet all the time we are dealing with the physically handicapped, the mentally handicapped, and the socially handicapped, let us also constantly preach the doctrine of prevention through wholesome community life and community living.

Now, it is a good deal more important that you should hear from those who have something to contribute from the field, and then I hope that Miss Atkinson will give us her words of blessing for another year.

The first speaker comes from Oregon—Mr. Norris E. Class, supervisor of child-welfare services of the State relief committee.

Aspects of State Child-Welfare Services

By Norris E. Class, *Supervisor, Child-Welfare Services, Oregon State Relief Committee*

Both from the program as it was printed and from Miss Atkinson's letter, I interpreted the topic that I might discuss briefly to be the operation of a division of child-welfare services at the State level. I believe that such a division can do two or three things at this particular point of our development.

First, that division can and should furnish consultation in certain areas of child-welfare service such as we have been discussing during these 2 or 3 days, as for example, substitute parental care, psychiatric problems, and possibly vocational counseling.

I do not believe, along with most of you, that this consultation is the same as field supervision. It is different in that it lacks the authoritative basis upon which supervision usually rests, and it is different in that it assumes, generally speaking, no responsibility beyond an educational level.

Consultation, as I see it, is the imparting of information. It is assisting with interpretation, and above everything else it involves dealing with or handling in a constructive manner this thing which is eternally present and which, for the lack of a better term, might be defined as the "will not to learn," which seemingly accompanies every situation in which there is a will to learn. Unless the consultant has the training and the experience to turn that negative factor or that resistance which arises into something that is constructive, into a form that may become the basis upon which this newer knowledge or understanding can be predicated, then the value of that consultation will last only as long as perhaps the relationship, the personal relationship, between the consultant and worker lasts and will have little or no professional significance.

Secondly, I think perhaps the function of a division of child-welfare services can be the assumption of responsibility for the more formal aspects of community organization and interpretation, in respect to meeting the needs of dependent children.

Now, in saying this I do not mean to imply that what the local worker does in the way of informal community organization and interpretation is any the less valuable, but from my own experience, at least, I do believe that the work that the local person does is most effective when it is done on a case basis, that is, when the worker goes to the county official or specific organization and can challenge them with a particular situation. Now if you grant that that is the primary approach in the local unit, I think you also will grant that in some instances the activity will not be geared in a direction that will fit the total picture.

Therefore the broader aspects of community organization and interpretation must generate, as I see it, from a State-wide appreciation of all the problems and all the needs. And I might add that in doing this job of interpretation the State division can possibly depersonalize the service, perhaps more than the local worker can, in order that the community may sense the professional basis upon which the program must eventually rest.

The community must sense that it is really more than Miss Jones' or Miss Black's personality that puts this particular task across, or if they do not, they will feel at a loss when Miss Jones or Miss Black leaves the community. I am quite convinced that only when such community interpretation is effectively engaged in by the State divisions will social work cease eternally starting from scratch.

The third function is that of research. Now, in some manner or other we have got to get away from the conception that everybody can do social research, that it is sort of God's universal gift to mankind. I often wonder how that idea came about, but what causes me most concern is how we are going to persuade individuals—coax them, or coerce them, or whatever is necessary—to give up that concept.

Research must be done if these programs are going to meet the needs of dependent children completely. Otherwise it will simply be a matter of shooting in the dark. We may hit the mark, but we most likely will not.

For performing social research, skill and technical training are essential if it is going to be done properly. For that reason I think—although I may be wrong about it—that it will have to be done, in the main, by the State division, because the workers in the local units do not have the training and the experience to do it, and even granting that they have the training and the experience, they do not have the time unless a worker is particularly or specifically appointed to do that task.

This does not mean that local workers will not manifest an experimental attitude of mind, that they will not continue to engage in a trial-and-error process in meeting the needs of dependent individuals or the requests of the community, but these things—experimental attitude of mind, trial and error, critical evaluations of what you are doing—are the attributes of any professional approach. They constitute a beginning for social research, but they are certainly not the final requirements.

These three functions, the rendering of consultation in certain areas of service to children, responsibility for the formal aspects of community organization, and engaging in social research in relationship to the needs of children, I believe might serve at this point of development as primary activities of the division of child-welfare services. They may not be the only services that a division may render. That division may have a psychologist and an expert in the field of nutrition, but I believe that these activities will be temporary in that they will be eventually taken over by the department of public welfare as a whole or may be delegated to some other branch of the public administration.

These three functions are things which we can do, and if we accept the tenets of several of our conference speakers that we be realistic, accepting limitations but at the same time striving for a certain amount of success, then perhaps we should attempt to do these things because they are seemingly within the realm of realization.

The CHAIRMAN. We will now have further discussion of the development of services for rural children by Miss Paula Frank, director of the Bureau of Child Welfare of the Louisiana Department of Public Welfare.

Development of Services for Rural Children

By Paula Frank, *Director, Bureau of Child Welfare, Louisiana Department of Public Welfare*

I feel just a little apologetic about having a topic which it seems to me has been practically and thoroughly covered by the speakers who preceded me.

It has seemed to us out of our experience that the basic essential in educating a community is interpretation on a case basis. In our communities a formalistic approach concerning structure or philosophy would be utterly futile, and we have not attempted it since we have felt that our differences of terminology might in themselves act as barriers, and that the very words we used might block understanding and raise questions in the minds of those that we wished to serve. And so we started out by placing a worker in a community and practically letting nature take its course. We were perhaps fortunate in having the right kind of cases so that certain dynamics occurred in the relationship of worker to the case, which in itself gave more momentum to the program than we could give it.

At that point I think a definite responsibility was placed upon the State office. You cannot continue to let nature take its course or I suppose it would run away just as floods and winds do; and so it was up to us to think as skillfully and objectively and with just as much analysis as was possible with our limited understanding, and to come to some kind of evaluation of what was happening, why it was happening, what we wanted from it, where it should logically and naturally go, and where it would go in spite of us.

We have tried the old method of arriving at conclusions without calling it social research. Through our supervision we have our finger on the pulse of the community. We know this is limited and does not completely meet the needs, but it does serve two purposes, one of channeling to our workers a certain security and a certain content which we think is one of our objectives in the State program, and then relaying back to us in the State office the actual work in the community which shows us whether our activities are in keeping with the needs in the community.

The other approach is not so well developed. It attempts to make our workers themselves responsible, willingly and actively responsible, for an evaluation of their own processes in the community, taking into consideration their relationships to the people, their oneness with the people and yet their differences; enough differences to be able to see what they are to see in their jobs, enough similarity and oneness to feel with the people in the community rather than to feel something about them. From that kind of objective, if we can attain it, perhaps there may come subjective valuations, and I think a certain amount of subjectiveness is wholesome in that relationship. We may have an idea of our own workers' needs, but we have not yet developed the technique in the State office to meet all those needs adequately; but we are beginning to be conscious of them and from that point we feel that we can go on toward some definite goal.

The other condition which I think the workers have come to realize is that they have a responsibility for certain programs in the community which must remain the community's, and that they merely act as the dynamics for leadership. They set in motion the things the community has been wanting to do but did not know how to accomplish because it never before had proper machinery available, and stimulate the use of latent resources which the community actually has for caring for its problems within its own area. When you work in a very rural area, as we do, you must face the fact that you are not going to have very high-powered scientific resources. If we did have them, it would be only in spots here and there beyond our reach, because of the lack of transportation facilities and because of their costliness.

In assuming that responsibility the workers have perhaps done more for the community to make it self-conscious, not about its problems and unhappy about them, but about what it can do that it has been wanting so long to do but has never had any opportunity to do. In the whole experience of the relief program a certain defeatist attitude seems to have arisen in many communities. If you could not solve the problem with money, then you could not do anything about it and you were very unhappy about it. I do not believe we have called attention to anything unknown, but I think we have made communities feel that something can be done about the things that they wish they might have struggled with earlier. In that sense it has been a question of giving leadership and devotion to what was already there, and eagerness to get started on developing something that was perhaps started long ago but was held back because of lack of leadership.

The other thing I think the workers have taken responsibility for out of our supervision or attempt at supervision from the State office has been developing within themselves a responsibility for their own professional growth. This probably sounds very fantastic to you when you realize they are in rural areas. Because we are so remote from the workers we had to resort to whatever devices we could that would sustain their relationship to professional life without making it artificial. In some instances this has tended to produce an artificial area for them. We have tried to make it something very real and very vital which made them happy to go on in spite of the disappointing and despairing phases of their jobs.

The rural child-welfare workers are sometimes hundreds of miles from anyone who speaks their kind of language, and it has been a real strain to develop a relationship to the community and yet sustain their relationship to the professional aspect of the job in the State office.

We have done a very limited job in consultant service, because we have no specialists and we haven't enough people to go around. In thinking of the social-research aspect of the job, it has not been an accumulation of material in the State office. It has been rather a living content which has had a constant flow back and forth from the community to the State office, with an interchange of ideas, re-valuation of the topic as it came up some months ago and as it is today, without thinking of it in terms of statistics, so much money, so many cases of this kind, so many problems here, and so many referrals there. It is what has been the content of thinking in that community, how it has expressed itself, and where we want to go from that point.

Mr. Carstens. Something that Miss Frank said reminds me to say just this one word. In rural organizations I think personal development comes harder than it does in city service. It is what you have made of yourself that is the bridge over which you are going to walk into the lives of people, particularly in rural service. Our next contributor to this discussion is Miss Anna Sundwall, chief of the Division of Child-Welfare Services, Utah State Department of Public Welfare.

Supervisory Functions of the State Child-Welfare Division

By Anna Sundwall, *Chief, Division of Child-Welfare Services, Utah State Department of Public Welfare*

It is very helpful, I think, to be preceded by two speakers who are in such conformity with my thinking, because it relieves me of a certain amount of responsibility. I can say they have covered my points and let it go at that. I thought, when Mr. Class was talking, "He forgot supervision of the case worker; I will make a point of that." I think I had better summarize what they said and not be called a contributor, because they certainly have made the contribution.

I do think it is necessary in developing services for rural children for the State to provide an adequate system of supervision. Miss Lenroot, in our opening speech, set the plan for developing an adequate system of supervision. It must be on a case-work approach to the needs of the local communities.

By supervision I mean seeing the job is done in an effective manner. We must see that the objectives of the plan we develop with the Children's Bureau are realized, and I think that that is the job of the State child-welfare division. We must make some pattern or give some direction to the local program, but we must not permit the local program to be rigid or to conform too closely to a set pattern.

I think the functions of supervision have been well covered. There is first the responsibility in the State division of helping the local group that is interested in developing child-welfare services to have a workable system. We cannot do a good job for children unless the mechanics, the system of the set-up, is sound. Therefore, our emphasis on this phase of the program has been necessary to do good child-welfare work.

The State division must also do something about financial supervision. We need to raise funds to support child-welfare services. It is true that the money we receive from the Children's Bureau is a great help, but as we move forward with our objectives we find increasing need for more funds. The State division can help the local workers by seeing that their program is supported. In addition to raising funds we have the responsibility of accounting for expenditures. As we interpret our program we must account for the money we spend.

Mr. Class expressed the importance of supervising statistical and reporting procedures. I agree with him that that is an essential function of the State child-welfare division. We must collect information about our program. We must be able to tell people what we are doing, not only by use of a case-by-case method, but on a scientific basis as well.

The fourth function is the supervision of case-work service, which has been discussed by Miss Frank. It is very important that we help the local workers on methods and techniques of case work. In our meeting this morning we indicated our need for some assistance: "How to write records," "how to write letters," "how to conserve the worker's time," "how to make her work more effective," "should she devote her time to community organization or should she limit it to service to children?" We must see that the work done with individual cases is of a standard which is acceptable to the State division and that there is some uniformity throughout the State in standards of care and service.

In the children's field we have established standards of care and service for private child-caring agencies. However, we are not quite so definite in what we expect to do for children in rural areas. Miss Hoey said the other day that we have no very satisfactory measuring stick of service. We should know each worker well, what she is doing, and what is happening to children. The State division certainly does have the responsibility of setting minimum standards of care and service.

In the realm of case-work supervision lies the function of providing consultation services. To me that is just one small phase of supervision. There are the special problems, the special cases which the child-welfare workers are encountering with which they need some help. They need the wisdom of someone who has worked longer and who knows more about a particular problem. I think the medical profession points the way in this matter: If a general practitioner has a puzzling case, something he is not equipped to deal with, he calls for the advice of a specialist. The State division must make available to the local workers these specialists. The methods of providing this service vary, of course, from State to State. The local needs determine what specialists are needed. I think there is need for case-work consultants, but there is also need for consultants in the realm of health, in the realm of speech pathology, and in the realm of nutrition—I could go on and on into the many very specialized problems that the workers have found and for which they have had to turn to the State for help.

In the supervision of the case-work service lies the responsibility of training and personnel development, which function has been mentioned. I have been very much interested in seeing what some workers in the Western States have done without close supervision. I think we have freed them from some of the limitations of a supervisor. They have had to do their own thinking. They have had to use their own initiative in developing the program. I do not know, but I think we are fortunate in having geographical factors which prevent close supervision, this close relationship between worker and supervisor, because some of the persons have grown tremendously on their job. From their growing we know something is happening to cases, as Dr. Plant said the other night. I think perhaps there will be some modification in our thinking about principles of supervision after a few years' demonstration of what a worker can do in an isolated rural community.

The last function which is very important in the State division is coordinating the many activities relating to children. Just the public programs alone are pretty overwhelming. Within the crippled children's program, maternal and child health, our workers are constantly inquiring, "Do I do this?", "Do I do that?", "Is that the nurse's function?" We must work with them in clarifying our own responsibility. There is also the whole realm of the private agency, which requires cooperative activity on the part of the division of child-welfare services. The State division as well as the local unit should participate in this interchange of information by getting to know what the other programs are all about, by defining responsibilities, by defining relationships, by seeing the program for children on a State-wide basis. I think that is the only manner by which we can fit in and decide what our program of child-welfare services should be. Where we are needed can be determined not by taking over a function that belongs to the schools or juvenile court, not by telling them what is wrong with their programs, but only by knowing these groups and working with them. I think we have pointed out the defects in all the other child-caring systems pretty well. We need to recognize the strengths of those programs and coordinate them so that the needs of children can be realized and new services for children can be devloped.

Mr. CARSTENS. We are very glad to have Miss Grace Reeder to speak to us. Miss Reeder is director of the Bureau of Child Welfare of the New York State Department of Social Welfare.

Relating the Special Child-Welfare Services to the Regular State Child-Welfare Program

By Grace A. Reeder, *Director, Bureau of Child Welfare, New York State Department of Social Welfare*

After three able discussants you see the only thing left for the fourth discussant is to take issue with something that has been said, and I cannot help commenting on what the last speaker said. I am perfectly willing to let a worker go without supervision if she has a pretty good start in the first place, but in New York State we have seen the results of some of these untrained workers in counties where they have had no supervision and no training to start with, and they were very near disastrous.

New York State is one of the old States in child welfare as in a good many other things, and we have had for a good many years a provision in our State constitution requiring that all charitable and eleemosynary institutions and agencies must be conducted pursuant to the rules of the State Board of Social Welfare to receive any public funds; and as our whole child-welfare system in New York State is pretty much built on the per capita payments for children to private agencies you can see that that is an important weapon. Besides that we have a legal provision that the State Department of Social Welfare has the right to inspect all places that care for children. That resulted early in an active division of child welfare within the State department, and last year when we combined the work of the State Department of Social Welfare with the Temporary Emergency Relief Administration, and had such a large volume of work to do with public assistance and child welfare, we decided to district the State, divide it into seven areas—New York City as one and six other areas—and distribute all of our work, and have the workers in child welfare as well as other fields in those area offices. We felt that would help in supervising the work in local districts.

We were fortunate in the early days of the 1900's, thanks to Miss Curry and the State Charities Aid, in the development in New York State of county units, county agencies for dependent children. They were developed first by the State Charities Aid, and many counties followed suit. You know the kind of public official who says that no private agency is going to tell him how to do his job and who at the same time is glad to imitate the kind of child-welfare agency that was set up in other counties that were willing to take the help of the State Charities Aid. By the time we were ready for the special child-welfare services under the Social Security Act all but four counties had children's workers.

I can hear you saying that this is a very rosy picture, but my answer is that you should see some of the children's workers. Because you happen to have children's workers in a rural county you may not be particularly fortunate, as we found out. There were some of these that had been without supervision. It was not only that; they had not had training to start with.

As we talked over the program with the Children's Bureau we realized that the thing New York State needed more than anything else was improvement in the quality of children's work, not in the quantity, and so we decided to work on that basis. We put a training unit in our child-welfare services. The problem now was to plan a training program and a supervision program that would work together and that would take into account the needs of an individual county, the way you would the needs of an individual child. We made surveys of every county in the State.

Then we reviewed the county situation and the quality of the work in each county with the area office in which the county was situated, which was responsible for the supervision of that county. We had a case committee that decided what the county needed—whether it needed a special training program (and when I say training I mean case-work training on the job), whether the county worker needed some very close supervision from the central office, or just what the county needed.

We decided that one county needed to have the child-welfare worker go to the New York School of Social Work, and we have been able to put in a substitute worker in that county. In the meantime this county decided that it did not want to give the substitute worker up when its regular worker came back, so an extra worker was put in the budget. We have tried to look at each county, all the counties, as we would a case load, and each county individually as we would an individual child, and it seems to me that in a State like New York we need to see that there are not any forgotten counties, that we have each one definitely in our mind as a county that we are going to try to work with to improve the quality of work.

To help us in improving quality, besides the child-welfare-services program, we had a law passed last year which provided that the State would reimburse the counties for the salaries of local personnel doing work with the county commissioner of public welfare to the extent of 40 percent, provided the workers had the qualifications set up by the State Department of Social Welfare. I can hear you saying, "Well, now that looks pretty good too," but that is not quite as good as it sounds, because we have a good many civil-service counties in the State, where the child-welfare workers have civil-service status; also we have counties where the workers have been for a good many years and the counties are satisfied with them. They think the workers are very good. We cannot walk into a county like that and say that the work is no good and we will not reimburse the community for her salary.

In some of those communities we have said, "We will reimburse for that salary if the person will take training from our child-welfare-services unit." When the instructor first went into some of the counties the local worker seemed to feel that this was just a bitter pill she was having to swallow in order to have her salary reimbursed by the State, but it has worked out well in several counties. We did set the date of November 1, after which time the standards we set up were going to be required for reimbursement.

I cannot help feeling that unless in this program we integrate special child-welfare-services work very closely with the "rgular" work of the State department, we are not going to have permanent results from it. We want to integrate it so that if the Federal Government stops giving us funds New York State will not know where the State department begins and the work with Federal funds leaves off. The State legislators will feel that it is all part of the same thing, and they will feel they have to go on with it because it is their program.

I was a little bit envious yesterday when I talked with one of the State representatives who said her State was just starting its child-welfare work on a county basis, because I thought, "Oh, well, she has not any of these old workers to worry about and inherit, and she has not any of this feeling that we must have a worker from the county, one with county residence." Incidentally, may I say that some of our counties have been very well brought up by Miss Curry, and they do not feel that they have to have someone who has a residence right in their county, but we still have some of that to overcome. I was feeling envious of this State, and then I began to think that we have some counties that have an awfully good record of work, and we have our work cut out for us to bring our other counties up to that standard. So I feel that Dr. Plant's story the other night seems to fit in here that we are all going to have different hats on in this child-welfare-services business. There are going to be special decorations on them in the different States, but they are all going to be built on the same pattern of interest and concern for the child and his family.

Mr. Carstens. And now there remains only this blessing, and I am very glad to turn the meeting back to Miss Atkinson.

Miss Atkinson. I should like to say just a word about Utah before I say my last word. I should not want anyone to get the wrong impression about the kind of job Miss Sundwall is doing out in Utah. I think when she talks about the development of workers having been stimulated by lack of supervision she is talking about that very constructive process which someone has referred to as supervised neglect.

I think one of the results of this conference of the people from all over the country who are carrying on this program, and our reason for planning such a meeting, is expressed in the following paragraph from the address which President Roosevelt gave last fall when he visited Bonneville Dam.

He said: "The responsibility of the Federal Government for the welfare of its citizens will not come from the top in the form of unplanned, hit-or-miss appropriations of money, but will progress to the National Capital from the ground up, from the communities and counties and States which lie within each of the logical geographical areas."

This conference probably should not be adjourned without a word of warning. There is not any question but that for 3 days we have all been thinking very well of ourselves. In view of the struggles and difficulties that most of us have gone through in order to get this program going, it is fitting that we have waxed somewhat expansive during the meetings. But I think it would be very unfortunate if we left Washington in such a glow that we went back to our respective communities and acted a little bit superior. We should recognize that some of the dangers in the program and some of the things that we have to learn are analogous to some of the dangers in adolescence and the things we have to learn as we grow up. Child-welfare services are in the process of growing up. Some of us who have been in the field much longer than many of you perhaps realize more clearly just what that means and what is involved. We realize also that we have been in a very advantageous position in the administration of title V, part 3, of the Social Security Act.

Ordinarily we do not think of a limited amount of money as giving persons or groups a superior advantage, but I think in this program we have been fortunate thus far in the small amount of money that we have had. Because the sums available have been so insignificant we have escaped some of the pressures that go hand in hand with large appropriations for public work, and we have been able to do some things that might have been impossible if we had had more money with which to initiate child-welfare services.

The fact that we have been in an advantageous position places upon us a very great obligation. We know that we cannot go forward with any kind of public-welfare program except as we go forward together.

It may be that we are, once more, acting on the theory that the world moves forward on the feet of little children—and that we are trying to push forward the whole program of public welfare through services to children. Be that as it may, it is important as we go home to remember our obligation to the whole welfare program and to see it not from the standpoint of one little segment but from the standpoint of the entire circle which encompasses all types of public service to citizens in need and distress.

We started this conference on Monday morning with the statement that we were going to limit the discussions, insofar as we could, to a consideration of the content of child-welfare services. We know that we can have no content without mechanism, and in these past 2 years the spotlight has necessarily been on legislation and administrative procedures. We hoped that we now had the kind of mechanism through which services to children would flow and that we could begin to think more in terms of what the program means in terms of the treatment of individual children and families. It seems to me that these 3 days have indicated interest in content and progress in getting beyond the initial emphasis upon administration.

I know of nothing more appropriate for the last word of this conference than a paragraph from a recent issue of the Birmingham News:

"The whole truth is simple and plain, it seems to us. It is that we all, all the children of the earth, are lost together for the time being, but still searching, and that if we find a good and secure way of life, we will find it together."

List of Representatives of State Welfare Departments Attending the Conference

Adie, David C., commissioner, New York State Department of Social Welfare.

Affleck, Mrs. Doris M., case supervisor, Delaware State Board of Charities.

Allen, Theodora, director, Children's Bureau, Public Welfare Board of North Dakota.

Alloway, Joseph E., executive director, Board of Children's Guardians, New Jersey Department of Institutions and Agencies.

Alper, Minnie, supervisor of child-welfare services, Division of Child Welfare, State Social Security Commission of Missouri.

Arnold, Mildred, director, Children's Division, Indiana State Department of Public Welfare.

Auer, Katharine, case worker, Michigan Children's Institute, State Welfare Department.

Baker, Mrs. Mary, assistant commissioner, Mississippi State Department of Public Welfare.

Bartlett, Ruth M., supervisor of child-welfare services, Division of Child Welfare, Illinois Department of Public Welfare.

Baughman, Wilhelmina, supervisor of local child-welfare services, Virginia Department of Public Welfare.

Becker, Harry, director, Child Welfare Division, Nebraska Department of Assistance and Child Welfare.

Berry, Mrs. Laura, county supervisor, Division of Child Welfare, Kentucky Department of Welfare.

Billopp, Katharine R., case supervisor, Division Child Welfare, Board of Public Welfare, District of Columbia.

Boan, Fern, director of training, child-welfare services, Oklahoma Department of Public Welfare.

Bonham, Martha A., director, Child Welfare Division, South Carolina State Department of Public Welfare.

Bost, Mrs. W. T., commissioner, North Carolina State Board of Charities and Public Welfare.

Bosworth, Mrs. Abigail, case worker, Michigan Children's Institute, State Welfare Department.

Bowen, Ruth, deputy director, Michigan State Welfare Department.

Bridge, Mrs. Ann Botsford, social-work consultant, child welfare, Social Work Department, Maryland Board of State Aid and Charities.

Buckley, Mrs. Mary, supervisor of child-welfare services, Bureau of Child Welfare, Connecticut State Public Welfare Council.

Butterfield, Dr. D. L., chief, Children's Bureau, West Virginia State Department of Public Assistance.

Carey, Cecilia, director, child-welfare services, Nevada State Welfare Department.

Carr, Louise K., technical consultant, child-welfare services, Department of Child Welfare, Florida State Welfare Board.

Chambers, Flonnia, district consultant, Division of Child Welfare, Kentucky Department of Welfare.

Class, Norris E., supervisor, child-welfare services, State Relief Committee of Oregon.

Chappell, Loretto, supervisor, child-welfare services, Division of Child Welfare, Georgia State Department of Public Welfare.

Closson, Eleanor, case supervisor, Division of Child Welfare, Board of Public Welfare, District of Columbia.

Coates, Elizabeth, welfare-training assistant, child-welfare services, Bureau of Child Welfare, New York State Department of Social Welfare.

Cook, Gladys, case worker, Michigan Children's Institute, State Welfare Department.

Cooper, Elizabeth, supervisor of child-welfare services, Michigan Children's Institute, State Welfare Department.

Coon, Helen F., social-service worker, Child Welfare Demonstration Unit, Board of Public Welfare, District of Columbia.

Cotton, Mrs. Dorothy W., case supervisor, Division of Child Welfare, Board of Public Welfare, District of Columbia.

Cuddy, Louise, child-welfare supervisor, Idaho Department of Public Assistance.

Dale, Timothy C., commissioner, Vermont Department of Public Welfare.

Deets, Mrs. Ruth, director, Division of Child Welfare, South Dakota Department of Social Security.

Denton, Virginia, assistant director for child-welfare services, Division of Child Welfare, North Carolina State Board of Charities and Public Welfare.

Dester, Laura, supervisor of child-welfare services, Oklahoma Department of Public Welfare.

Dew, Mrs. Eleanor A. R., consultant, Child Welfare Division, South Carolina State Department of Public Welfare.

Donahue, A. Madorah, director, Child Welfare Demonstration Unit, Board of Public Welfare, District of Columbia.

Drayer, Dr. C. S., director and psychiatrist, Tri-County Child Guidance Center, Harrisburg, Pennsylvania.

Dudley, Virginia, social worker, Demonstration Area, Bridgton, Maine.

Dunn, Loula, commissioner, Alabama Department of Public Welfare.

Ehman, Evelyn, psychologist, Division of Child Welfare, Illinois Department of Public Welfare.

Faatz, Anita J., director, Social Work Department, Maryland Board of State Aid and Charities.

FitzSimons, Ruth, assistant director, Washington Department of Social Security.

Fortune, Gertrude, superintendent, Bureau of Charities, Division of Public Assistance, Ohio Department of Public Welfare.

Foss, Lillian F., supervisor of child-welfare district service, Massachusetts Department of Public Welfare.

Frank, Paula, director, Bureau of Child Welfare, Louisiana Department of Public Welfare.

Garnett, A. W., director, West Virginia State Department of Public Assistance.

Golway, Everett A., social-service worker, Child Welfare Demonstration Unit, Board of Public Welfare, District of Columbia.

Gordon, Mildred, case supervisor, Division of Social Security, Rhode Island State Department of Public Welfare.

Goudy, Elmer R., administrator, State Relief Committee of Oregon.

Greenhill, Mrs. Violet S., chief, Division of Child Welfare, Texas State Board of Control.

Gresham, Mrs. Judith Hall, director, Bureau of Child Welfare, Alabama Department of Public Welfare.

Griffin, Louise, supervisor of child-welfare services, Children's Division, Indiana State Department of Public Welfare.

Gullixson, Elvira, case consultant, Children's Bureau, Minnesota State Board of Control.

Haines, Alice R., supervisor of child-welfare services, Department of Child Welfare, Florida State Welfare Board.

Hankins, Mildred, district supervisor, Bureau of Social Welfare, Maine Department of Health and Welfare.

Haynie, Gussie, commissioner, Arkansas Department of Public Welfare.

Hewins, Katherine P., director of case-work services, Vermont State Department of Public Welfare.

Houghton, Grace M., supervisor of field service, Bureau of Child Welfare, Connecticut State Public Welfare Council.

Hubbell, Helen C., supervisor of rural extension unit, Division of Community Work, Pennsylvania Department of Welfare.

James, Arthur W., commissioner, Virginia Department of Public Welfare.

Johnson, Jean, supervisor of child-welfare services, Children's Bureau, Minnesota State Board of Control.

Johnson, Milton G., child-welfare consultant, Division of Child Welfare, Social Security Commission of Missouri.

Kelly, Rose Marie, supervisor of special demonstration units, Child Welfare Division, South Carolina State Department of Public Welfare.

Leeper, Charlotte, case-work supervisor, Division of Welfare, New Hampshire State Board of Welfare and Relief.

Lockard, Winifred, county children's worker, Burnett County, Wisconsin.

MacDonald, Norman W., director, Bureau of Social Welfare, Maine Department of Health and Welfare.

Marks, Mrs. Mabel B., director, Division of Child Welfare, Kentucky Department of Welfare.

McGonagle, Mrs. Ellen, district supervisor, child-welfare services, Children's Bureau, Virginia Department of Public Welfare.

Mitchell, Lily E., director, Division of Child Welfare, North Carolina State Board of Charities and Public Welfare.

Muhlbach, Lillian, acting supervisor, Division of Child Welfare, Children's Bureau, West Virginia State Department of Public Assistance.

Muller, Beth, director of child welfare, Arkansas Department of Public Welfare.

Nygard, J. Wallace, acting director, Division of Institutions, North Carolina State Board of Charities and Public Welfare.

O'Kelly, Mrs. Phyllis, child-welfare assistant, Anson County, North Carolina.

Page, Harry O., director, Division of Welfare, New Hampshire State Board of Welfare and Relief.

Parrott, Lena, consultant, child-welfare services, Bureau of Social Welfare, Maine Department of Health and Welfare.

Perkins, Juanita V., supervisor of child-welfare unit and training center, Jefferson County, Colorado.

Pyles, Mary Lois, director, Division of Child Welfare, State Social Security Commission of Missouri.

Ramsay, C. F., superintendent, Michigan Children's Institute, State Welfare Department.

Rankin, Mrs. Norma, director of child-welfare services, Division of Child Welfare, Texas State Board of Control.

Reeder, Grace A., director, Bureau of Child Welfare, New York State Department of Social Welfare.

Reinhold, Rosemary, chief, Division of Community Work, Pennsylvania Department of Welfare.

Richardson, Helen, supervisor of child-welfare services, Bureau of Charities, Division of Public Assistance, Ohio Department of Public Welfare.

Roberts. Mrs. Mary Edwards, director, Child Welfare Division, Tennessee Department of Institutions and Public Welfare.

Smith, Marie C., director, Child Welfare Division, Colorado Department of Public Welfare.

Smith, Robert J., deputy commissioner of welfare, Connecticut.

Smith, Vallie, supervisor of child-welfare services, Child Welfare Division, Tennessee Department of Institutions and Public Welfare.

Stalnaker, Mrs. Frances F., child-welfare consultant, Division of Child Welfare, Children's Bureau, West Virginia State Department of Public Assistance.

Steele, Frances, director, Division of Child Welfare, Georgia State Department of Public Welfare.

Stephens, Anne, supervisor, Division of Relief, New Hampshire State Board of Welfare and Relief.

Stoddard, Effie, homefinder, Crippled Children's Division, South Carolina State Department of Public Welfare.

Stokes, Lavinia, consultant, Child Welfare Division, South Carolina State Department of Public Welfare.

Street, Elwood, director, Board of Public Welfare, District of Columbia.

Sundwall, Anna, chief, Division of Child Welfare, Utah State Department of Public Welfare.

Swift, Mrs. Helen C., supervisor, Division for Children, Washington Department of Social Security.

Sycle, Margaret, field worker, Children's Bureau, Virginia Department of Public Welfare.

Taft, Laura L., director of child-welfare services, Division of Child Welfare, Iowa State Board of Social Welfare.

Thompson, Mrs. Elizabeth, supervisor of aid to dependent children, Tennessee Department of Institutions and Public Welfare.

Thornhill, Dora Page, child-welfare consultant, Division of Child Welfare, Children's Bureau, West Virginia State Department of Public Assistance.

Trout, Bessie, welfare-training assistant, Child Welfare Services, Bureau of Child Welfare, New York State Department of Social Welfare.

Tryon, Anne, Children's Bureau, West Virginia State Department of Public Assistance.

Tynes, Harriet L., director of child-welfare services, Children's Bureau, Virginia Department of Public Welfare.

Underhill, Bertha S., child-welfare agent, Division of Child Welfare, California Department of Social Welfare.

Walcott, F. C., commissioner of welfare, Connecticut.

Walton, Frank T., superintendent, Division of Child Welfare, Iowa State Board of Social Welfare.

Webb, Frank, secretary, Public Welfare Board of North Dakota.

Webster, Josephine, director of child-welfare services, Bureau of Child Welfare, New York State Department of Social Welfare.

Willson, E. A., executive director, Public Welfare Board of North Dakota.

Withers, Elizabeth, consultant, Child Welfare Division, South Carolina State Department of Public Welfare.

Wretling, Alma, secretary, Division of Child Welfare, Montana Department of Public Welfare.

Yerxa, Elizabeth, director, Juvenile Department, Wisconsin State Board of Control.

Zane, C. Rollin, executive director, Delaware State Board of Charities.

Zewadski, Mrs. Irene Dayton, director, Department of Child Welfare, Florida State Welfare Board.